



Assessment of Knowledge, Perceptions, and Attitudes of Mental Health: The Garment Industry in Jordan

FEBRUARY 2022

PREFACE

Over the past 12 years, Better Work Jordan has been working with national constituents to improve working conditions – making work safer, addressing discrimination and improving compliance to many areas of labour law. In particular, dramatic progress has been made on eliminating forced labour, and improving living and working conditions for migrant workers.

That said, challenging circumstances and serious issues of mental health have continued to affect the migrant workers who are the backbone of the sector. In recent years, there have been multiple cases of suicides and attempted suicides partly attributed to the economic uncertainty that workers face, as well as isolation from and worries about distant family members' health and well-being. The entire sector was alarmed at this trend. While we knew it disproportionality affects women workers, we quickly learned that collectively, we did not know enough about why this is happening and what could be done to support better mental health and to stop this tragedy.

The sector employs approximately 62,000 workers, of which roughly 75% are migrant workers from Bangladesh, Sri Lanka, India, and Nepal. Jordanian workers make up the remaining 25%. Nearly 75% of the production workforce are women. We know that migrants face many stressors throughout the migration, relocation and integration process and the impact of these varies depending on individual vulnerabilities and coping strategies. Long working hours, pressures to meet production targets, violence and harassment, poor dormitory conditions, language barriers and discrimination can each contribute to poor mental and physical health. We also need to take into consideration that migrant workers have their own ideas and attitudes about mental health and seeking help, based on their cultural and religious beliefs and mental health literacy.

Research globally shows that while many people have knowledge about the causes and prevention of major physical health problems, such as cancer and cardiovascular diseases, knowledge about mental disorders has generally lagged behind.¹ Mental health literacy is particularly low in developing countries, including those from which most migrants in Jordan's garment sector come from.²

While there are many complexities surrounding the mental health of workers in Jordan's sector, our conclusion remains straightforward: fatalities resulting from circumstantial mental health problems are both tragic and unacceptable. This calls for urgent intervention and support to enhance and protect the mental health of workers.

Better Work Jordan has undertaken a Mental Health Project, including this research assessment, to explore the knowledge, perceptions and attitudes of workers and stakeholders in the garment industry around mental health. This assessment was conducted by the Information and Research Center – the King Hussein Foundation (IRCKHF) between June and November 2021. This assessment also draws on discussions with stakeholders, including experts from government entities, non-governmental organizations, international organizations, workers in the garment sector, multinational brands, factory management, labor unions, and academic institutions. This process has made clearer our understanding of the climate of Jordan's garment industry surrounding mental health, and how this impacts the emotional and physical lives of all workers, including the most vulnerable. The assessment also includes practical recommendations for ministries, trade unions, and embassies, as well as recommendations aimed at factory senior management, middle management, and workers. These range from creating medical referral systems to offering in-factory educational workshops and counselling.

This is only the beginning of our ongoing efforts to help support and protect the mental health of Jordan's garment workers. We offer a heartfelt thank you to all those who so readily and candidly shared their insights and experiences with us to inform this work. We are inspired by your commitment to improving the lives of migrant workers in Jordan. We all have important and urgent action to take, and we join you in this endeavor.

Dan Rees

Better Work Branch Chief
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¹ Thornicroft, G. et al (2011), *Oxford Textbook of Community Mental Health*. Oxford University Press.

² Uddin, M. N., Bhar, S., & Islam, F. (2019). *An assessment of awareness of mental health conditions and its association with socio-demographic characteristics: a cross-sectional study in a rural district in Bangladesh*. BMC health services research, 19(1), 562.

Better Work Jordan: Better Work Jordan was created in 2009 as a partnership between the UN's International Labour Organization (ILO) and the International Finance Corporation (IFC), a member of the World Bank Group. The programme engages with workers, employers, and governments to improve working conditions and boost the competitiveness of the garment industry. For more information, see: <https://betterwork.org/where-we-work/jordan/>

Information and Research Center – King Hussein Foundation: The Information and Research Center – King Hussein Foundation (IRCKHF) was established in 1995 as the National Task Force for Children. Today, the IRCKHF mobilizes knowledge for positive social change. IRCKHF's mission is to serve as a catalyst for socio-economic development by conducting inclusive research, evidence-based advocacy, and knowledge sharing with practitioners, policymakers, and civil society on issues of human rights, gender, and social justice. For more information, see: www.irckhf.org.

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This research would not have been possible without the workers and stakeholders who generously offered their insights and shared their experiences.

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Acronyms

BWJ	Better Work Jordan
CBA	Collective Bargaining Agreement
FGD	Focus Group Discussion
IDI	In-depth interview
IFC	International Finance Corporation
ILO	International Labor Organization
IFHNHF	Institute for Family Health – Noor Al Hussein Foundation
IRCKHF	Information and Research Center – King Hussein Foundation
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MOL	Ministry of Labor
QIZ	Qualifying Industrial Zones
NTC	National Technical Committee
TVPRA	Trafficking Victims Protection and Reauthorisation Act
USJFTA	United States-Jordan Free Trade Agreement

Executive summary

The garment industry in Jordan has seen significant growth in the last ten years. As of early 2021, the sector employed approximately 66,000 people, of which roughly 75% are migrant workers from Bangladesh, Sri Lanka, India, and Nepal. Jordanian workers make up the remaining 25% of employees. Nearly 75% of the production workforce are women.¹

Better Work Jordan (BWJ), a joint programme of the International Labour Organization and the International Finance Corporation, works with stakeholders in the Jordanian garment industry to improve working and living conditions for workers while boosting the sector's competitiveness. In January 2021, BWJ started a mental health project that focuses on building garment workers' resilience against mental health risks, ensuring factory-level support exists, and increasing accessibility of mental health referral systems for all workers.

As part of the mental health project, this assessment was commissioned by BWJ and conducted by the Information and Research Center – King Hussein Foundation (IRCKHF) between June and November 2021 in cooperation with the Institute for Family Health – Noor Al Hussein Foundation (IFHNHF). The assessment aimed to **explore the knowledge, perceptions, and attitudes of workers and stakeholders in the garment industry around mental health.**

The assessment was qualitative and based on 12 focus groups discussions (FGDs) and 19 in-depth interviews (IDIs) with male and female, Jordanian, Bangladeshi, Nepalese, Indian, and Sri Lankan workers in the garment industry. Additionally, 21 key informant interviews (KIIs) were conducted with the management and staff of different factories as well as external stakeholders, including the Ministry of Health (MOH), Ministry of Labour (MOL), Embassy of India, Embassy of Sri Lanka, J-Gate and the Trade Union of workers.

The assessment explored four main themes: **knowledge** of mental health issues, causes, and treatment, **perceptions** on mental health and individuals going through mental health problems, **attitudes** towards seeking help, and **experiences** related to mental health. The interview and focus group question guides included open-ended questions as well as vignettes exploring different scenarios. The following are the main observations from this assessment:



Knowledge:



- **This research found that workers and stakeholders demonstrated varied levels of knowledge around mental health problems and causes. Workers exhibited lower levels of knowledge than stakeholders.** Jordanian workers, especially women, demonstrated the highest level of knowledge among all workers. While stakeholders have higher levels of knowledge around mental health issues, there are still some groups, especially factory staff, who exhibited limited knowledge on the subject.
- **While the majority correctly identified that extreme psychological stress from major life events can cause mental health problems, there were mixed opinions on whether biological or spiritual factors can potentially cause mental health problems.** Some migrant workers, particularly those from India and Bangladesh, believed that spiritual factors (such as being cursed or possessed) cause mental health problems.
- **Lack of knowledge around mental health problems and causes is problematic** because it impacts the way management and staff interpret and diagnose mental health problems and in turn provide the proper course of treatment to workers. It also affects the willingness and responsiveness of workers to seek or accept the correct treatment.

Perceptions:



- **This assessment found that there are negative connotations with mental health and those suffering from mental health issues.** This was evident by some of the words used by workers and stakeholders to describe individuals going through mental health problems, including “anger”, “difficulty in deal”, “crazy”, “insane”, and “disturbed”. This was confirmed by stories cited by workers about individuals going through mental health problems and how they were treated in their communities. Participants shared a variety of explanations regarding the way their communities treated individuals suffering from mental health issues, saying that while some individuals might be accepting or supportive, others might treat victims apathetically, and oftentimes violently – by attempting to ignore and or isolate them. Workers from both Sri Lanka and Bangladesh shared that people suffering from mental health problems might be “tied” down or “chained” to contain the threat that they pose.
- **There are differences across nationalities in the way workers perceive mental health issues and causes.** Among notable differences was the issue of religion and faith, which was only brought up by Jordanian workers who believed that individuals who have faith in God are less likely to go through severe mental health issues. Another difference is the strong belief in spiritual causes such as being possessed by ghosts or the devil, which some migrant workers expressed.

- **The stigma surrounding mental health creates many barriers.** The differences in perceptions around mental health issues and causes greatly impact the extent to which mental health patients are willing to disclose or talk about their mental health problems, their willingness to seek help, and their inclination to accept medical treatment. Those in an environment or community that stigmatizes mental health issues are less likely to be open about their mental health issues. Furthermore, negative connotations with mental health and individuals going through mental health problems will likely impact how management, staff, and workers treat those suffering from mental health issues, increasing the likelihood of exclusion and stigmatization.

Attitudes towards seeking help:



- **Several factors impact the likelihood of workers seeking help as well as the type of help they seek.** Barriers to seeking help from factory management and staff include i) the fear that problems will become bigger and more exposed, resulting in the spread of rumors, and ii) fear of jeopardizing their jobs. However, those who stated that they would seek help from factory management and staff stated that factory management and staff tend to have solutions to problems. Many workers stated that they would confide in friends with personal problems as friends can be trusted in keeping problems private.
- **The stigma surrounding mental health and the differences in the levels of knowledge and perceptions around mental health issues, causes and treatment create barriers to addressing mental health issues in the workplace.** Negative connotations (as explored in the ‘perceptions’ section) around mental health issues and individuals create barriers to speaking up and seeking help from management and staff. Cultural differences in perceptions and beliefs create challenges in the way factory management can raise awareness around mental health issues and advocate correct professional treatment.
- **Failure to correctly address mental health issues in a timely, professional, and appropriate manner can negatively affect workers with mental health issues.** This could adversely impact the health and well-being of workers and also affect the general morale among other workers. Incorrectly handling mental health cases can perpetuate existing myths surrounding mental health among workers and staff.

Experiences:



- **There was a reluctance by workers, especially migrant workers, to talk about stories or instances of other workers experiencing mental health problems.** This reluctance could possibly be due to a lack of confidence in openly discussing mental health issues and problems and/or fear of retribution.

- **Some female Jordanian workers from different factories spoke about verbal abuse they have experienced by supervisors, including shouting and screaming, which negatively affects their mental health.** This finding is in line with results from the 2021 survey conducted by BWJ with workers, supervisors, and managers in the garment sector, which found that verbal abuse is the most common concern cited by workers, as 36% of workers stated this concern – the highest percentage since 2019. Concerns related to verbal abuse were mainly vocalized by Jordanian workers, as 62% reported being concerned with verbal abuse. Concerns with verbal abuse were found to correlate with lower wellbeing.²
- **Furthermore, workers who shared stories spoke about the ways in which the management helps those who have been “attacked by spirits or ghosts.”** In most cases, workers are taken to the medical/sick room. A “holy person” such as the Mullah or Sheikh is then brought in to recite the Quran, for example, or other religious texts to calm the worker down.
- **Several stakeholders from factory management and staff were reluctant to discuss cases of mental health problems at the factories.** Cases of suicide that were mentioned by factory management and staff were all perceived to be a result of family or relationship problems rather than reasons related to the work environment, pressure, or living conditions.
- **Some migrant workers claimed to have encountered someone experiencing mental health issues back home.** Across all nationalities, there was no clear answer as to how these societies treated or accepted mental health problems. Participants shared a variety of explanations saying that while some individuals might be accepting or supportive, others might treat victims apathetically, and oftentimes violently. **Workers from India were more likely to give precedence to religious or spiritual treatment for mental health problems.** Multiple responses by workers from India indicated that the first course of action for solving someone’s mental health disorder would be seeking out religious counsel from an Imam or a spiritual healer.

The assessment provides national-level recommendations targeting the Ministry of Health, Ministry of Labor, the General Trade Union of Workers in Textile Garment & Clothing Industries, and the embassies of migrant workers. It also includes factory-level recommendations targeting all stakeholders, including factory management and staff as well as workers. The assessment recommends the need for further awareness-raising efforts on the issue of mental health problems, causes, and solutions. Nationality and culture-specific differences should be catered to when designing and implementing mental health activities, as these nuances will impact how receptive workers are and to what extent their perceptions can change. In addition, it is recommended that national stakeholders continue to work on enhancing the working and living conditions of workers in the garment sector.

1. Introduction and overview

The garment industry in Jordan has seen significant growth in the last ten years. The sector is primarily driven by large exports to the United States under the US-Jordan Free Trade Agreement (USJFTA). In 2020, exports were valued at USD 1.6 billion, making up 22% of all exports. As of early 2021, the sector employed approximately 66,000 people, of which roughly 75% are migrant workers from Bangladesh, Sri Lanka, India, and Nepal. Jordanian workers make up the remaining 25% of employees. Nearly 75% of the production workforce are women.

Better Work Jordan (BWJ), a joint programme of the International Labour Organization and the International Finance Corporation, works with stakeholders in the Jordanian garment industry to improve working and living conditions for workers while boosting the competitiveness of the sector. In January 2021, BWJ started a mental health project that focuses on building garment workers' resilience against mental health risks, including ensuring that factory-level support exists and mental health referral systems are accessible to all workers.³

As part of the mental health project, this assessment was commissioned by BWJ and conducted by the Information and Research Center – King Hussein Foundation (IRCKHF) between June and November 2021 in cooperation with the Institute for Family Health – Noor Al Hussein Foundation (IFHNHF). The assessment aimed to **explore the knowledge, perceptions, and attitudes of workers and stakeholders in the garment industry around mental health**.

The assessment was based on 12 focus groups discussions (FGDs) and 19 in-depth interviews (IDIs) with male and female, Jordanian, Bangladeshi, Nepalese, Indian, and Sri Lankan workers in the garment industry. Additionally, 21 key informant interviews (KIIs) were conducted with the management and staff of different factories as well as external stakeholders, including the Ministry of Health (MOH), Ministry of Labour (MOL), Embassy of India, Embassy of Sri Lanka, J-Gate and the Trade Union of workers.



2. Background

2.1 Mental health

Mental Health is defined by the World Health Organization (WHO) as a state of well-being in which the individual realizes their own abilities, can cope with everyday stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.’ The mental health of a person can be impacted by several social, psychological, and biological factors at any point in time. Poor mental health is associated with ‘rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health, and human rights violations.’⁴

Research shows that stigma and discrimination are widely experienced by people with mental disorders, which impacts them in different aspects, including employment, social activities, relationships, marriage, etc. Boner and Dickel define an attitude as ‘an evaluation of an object of thought ranging from the mundane (ordinary) to the abstract, including things, people, groups and ideas.’⁵ When most people develop negative attitudes toward an individual or a group of characteristics associated with a group, it gives rise to stigma and leads to discriminatory behavior.⁶

The fear of being discriminated against and stigmatized has been reported to be a key barrier to seeking mental health treatment and support. The stigma surrounding mental health not only hampers treatment-seeking but may also delay the healing process.⁷

Research assessing the knowledge, attitudes, and perceptions toward people with mental disorders has been conducted in different countries and across several settings, including communities, schools, universities, and health clinics. These studies showed that knowledge and attitudes differ from country to country, and vary according to culture, age, gender, socio-economic background, education, etc.⁸





2.2 The garment industry in Jordan

Since the signing of the Qualifying Industrial Zones (QIZ) agreement with the United States in the mid-1990s, the Jordanian garment industry has grown rapidly, which guaranteed the tariff-free entry of garments produced in Jordan into US markets. The United States-Jordan Free Trade Agreement (FTA), established in 2001 and fully implemented in 2010, further expedited this trend. Currently, garments are one of Jordan's leading exports, valued at 1.9 billion USD in 2019 and comprising approximately 23% of the country's GDP.⁹ The garment industry in Jordan consists of more than 75 factories housed in 14 QIZs throughout the country, producing goods for international retailers such as Gap, Walmart, Calvin Klein, and Sears.¹⁰

Although Jordan has adopted protectionist policies aimed at reducing dependence on foreign labour and increasing the number of Jordanian workers in the garment industry, these drives have proved largely unsuccessful, perhaps due to national stigma surrounding low-skilled labour.¹¹ Of the approximately 66,000 workers in the garment industry, roughly three-quarters are migrant workers.¹² The vast majority of these migrants are originally from Bangladesh (over 50%), but large subsets are from India, Sri Lanka, Myanmar, and Nepal. The industry is also female-dominated, with women making up almost 75% of the workforce.¹³

The garment industry has come under fire and faced criticism from numerous human rights groups over the years. Many argue that the Jordanian policy on labour migration propagates exploitation of the workforce. Jordan lacks a national policy on labour migration. Rather, individual laws address the entry, exit, and stay in Jordan of migrant workers. Labour policies regarding garment workers are outlined in Law No. 24 on Residence and Foreigners' Affairs, which details the current immigration framework, called the kafala, or sponsorship, system.¹⁴ Under this framework, migrant workers must be sponsored, usually by a future employer, to enter the country. Although the system technically allows workers to change employers, this can only be done when there is a factory shutdown or where the worker files a formal complaint with the Ministry of Labour (MoL). However, most workers are unaware of these systems, and renewal of residency permits must also be done by the employer, further limiting worker freedoms.¹⁵

The industry has also faced heavy criticism for conditions inside both factories and living areas. These charges are significant as employers in the Jordanian garment industry provide accommodation for 75% of the workforce, essentially meaning that for many of the workers, there is no real distinction between the workplace and the home.¹⁶ Workers and civil society groups have accused factories of providing poor living and working conditions.¹⁷ A positive development for migrant workers was the creation in 2013 of the Collective Bargaining Agreement (CBA), which included a unified contract for all migrant workers, standardizing contracts, and giving workers a coherent layout of their rights and conditions. The CBA further regulates other aspects, including work hours, wages and bonuses, and health and occupational safety. Although the CBA regulates employee conditions, there is still large-scale non-compliance with and ignorance of its mandates.

In 2008, the International Labour Organisation (ILO), International Finance Corporation (IFC), and the Government of Jordan created Better Work Jordan (BWJ). This programme aims to ensure the application of national labour laws and guarantee favourable working and living conditions for workers. BWJ brings together different stakeholders from the global garment manufacturing industry to ‘improve working conditions, enhance respect for labour rights and boost competitiveness.’ This flagship programme works with 65,026 workers in 88 registered factories.¹⁸

The 2021 BWJ annual report underlines the impact of COVID-19 on the garment industry both worldwide, which reportedly saw contractions of between 30–50%, and in Jordan, where the impact was more limited as the industry saw only a 15% reduction in garment exports – sales projections suggest that a full return to pre-COVID sales is expected by the end of 2021. The report also highlights some improvements that have taken place in the garment industry as well as non-compliance violations, including:

- **Child Labour:** there were no cases of garment workers under the age of 16 (the minimum legal age for employment in Jordan), but the report recognizes that cases of child labour are notoriously difficult to identify because of the widespread use of false documentation.
- **Discrimination:** the most prominent form of gender discrimination continues to be pregnancy tests for migrant workers during recruitment, which has not noticeably improved in recent years. Additionally, although none of the factories were classed as non-compliant for subjecting workers to sexual harassment, surveys of works show that it is nonetheless a pressing problem for many migrant workers – 18% of workers stated that they or their co-workers had concerns over sexual harassment. Other forms of discrimination continue to be prevalent: 17% of factories failed to hire the requisite number of workers with disabilities, and 6% paid attendance bonuses to Jordanians but not to migrant workers.
- **Forced Labour:** the report finds that significant improvements have been made in this field in recent year. In 2016, the US Department of Labor removed garments produced in Jordan from the Trafficking Victims Protection and Reauthorisation Act (TVPRA). However, major violations nonetheless occurred in 2020: two companies were shown to have withheld wage payments and used threats to coerce workers to work, whereas another factory kept workers’ passports in a locker to restrict their movement.

- **Freedom of Association and Collective Bargaining:** all factories in Jordan continue to be non-compliant when it comes to workers' ability to form and join unions since Jordan has yet to ratify the ILO Convention No. 87 on the Freedom of Association and Protection of the Right to Organise. Additionally, although the industry has ratified a series of Collective Bargaining Agreements (CBA) to support workers' rights, 81% of factories failed to fully implement all agreed-upon provisions of the CBA .
- **Compensation:** disruptions to compensation were widespread in 2020 because of COVID-19. Some cases were not violations, though they still were disruptive for workers, whereas others were cited as non-compliance, and cases of non-compliance increased compared to 2019. Additionally, wages dropped by an average of 10 JD per month or 5% of 2019 wages, despite a series of government-issued Defence Orders which aimed to prevent this. Working hours also decreased in 2020 due to a decrease in the number of workers allowed in factories and the reduced availability of overtime work.
- **Occupational Safety and Health:** most non-compliance violations continue to fall under this category, and many fundamental issues that were evidenced in previous years were exacerbated by the pandemic as the cleanliness and sanitation of work and living spaces became even more crucial.

2.3 Factors impacting the mental health of migrant workers in Jordan's garment sector

BWJ conducted research in 2019 exploring the overarching factors that adversely impact the mental health and well-being of migrant workers in Jordan and evaluated existing mental health services and potential barriers to access. The research was based on 28 semi-structured interviews with key stakeholders and mental health experts, and a review of academic literature. The research also analyzes surveys conducted with workers between 2009-2016.¹⁹

The research found four main factors that impact the mental health of migrant garment workers in Jordan and five key barriers to accessing existing mental health services. The factors affecting mental health include i) workplace conditions, including the physical and psychological demands of a job coupled with low decision-making power of workers regarding these conditions; ii) living conditions including the quality of housing; iii) personal conditions, including the environmental adjustments to leaving one's country and home, language and communication barriers, culture shock, losing familiar support networks and financial barriers; and v) gender dynamics in the workplace, including the concentration of women in low-paid and low-skilled jobs as well as sexual harassment.²⁰

The impact of these factors will vary from one worker to another, depending on the worker's unique mental health status as well as the migration experience that they have been through.²¹

Factor	Sub factor	Problem	Effect
WORKPLACE CONDITIONS	Repetitive work	<ul style="list-style-type: none"> • High psychological job demands • Low worker decision latitude 	<ul style="list-style-type: none"> • Depression • Loss of self-esteem • Passive and restricted leisure behavior
	Mismanaged expectations	<ul style="list-style-type: none"> • No pre-departure training • Short orientation • Lack of information about work conditions • short acclimation periods 	<ul style="list-style-type: none"> • Depression • Loss of self-esteem • Passive and restricted leisure behavior
LIVING CONDITIONS	Dormitories	<ul style="list-style-type: none"> • High population density • Lack of personal space • Poor living conditions (accommodation cleanliness, protection against diseases and protection against heat, dampness and cold). 	<ul style="list-style-type: none"> • Elevated levels of psychological distress
PERSONAL FACTORS	Environmental adjustments	<ul style="list-style-type: none"> • Change in climate and food • Change in culture 	<ul style="list-style-type: none"> • Culture shock
	Language & communication barriers	<ul style="list-style-type: none"> • Challenge in communicating with management and workers 	<ul style="list-style-type: none"> • Loss of confidence in communicating in a foreign language • Not feeling empowered or equipped to share in case of concerns and grievances
	Loss of familiar support structures	<ul style="list-style-type: none"> • Children and spouse left behind • Challenges in communicating with family 	<ul style="list-style-type: none"> • Isolation • Home-sickness
	Financial pressures	<ul style="list-style-type: none"> • Work overtime (up to 12 hours per day) • Unclear financial arrangement between worker and family back home 	<ul style="list-style-type: none"> • Physical stress and burnout • Frustration
GENDER DYNAMICS		<ul style="list-style-type: none"> • Women concentrated in low-paying low-skilled jobs • Sexual harassment by colleagues and employers 	<ul style="list-style-type: none"> • Stigma and marginalization • Acute stress or post-traumatic stress • Reduced work performance

Barriers to accessing adequate mental health services include:²²

- 1 **Gaps in mental health service provision:** there are no services that specifically target migrant workers in Jordan. Services that are available to non-Jordanians are mostly directed to refugees.
- 2 **Financial barriers to existing mental health services:** public mental health services are not free for migrant workers and pose a financial burden that many cannot afford.
- 3 **Resource and capacity:** appropriate, accessible, and reliable mental health services are still lacking in Jordan's private and public health centers. Additional capacity barriers include language and cultural barriers in receiving mental health treatment.
- 4 **Limitations in coordination:** mental health programming is provided by the Ministry of Health (MoH) and the Mental Health and Psychosocial Support (MHPSS) working group, which coordinates with non-governmental organizations in the provision of services. Better coordination is required to ensure optimal service delivery and coverage.
- 5 **Stigma and lack of mental health awareness:** mental health is largely perceived as a sign of weakness due to the social and cultural stigmas associated with mental health in Jordan and the region. Individuals seeking mental health support are often stigmatized.

2.4 Mental health of workers in the garment industry in Jordan

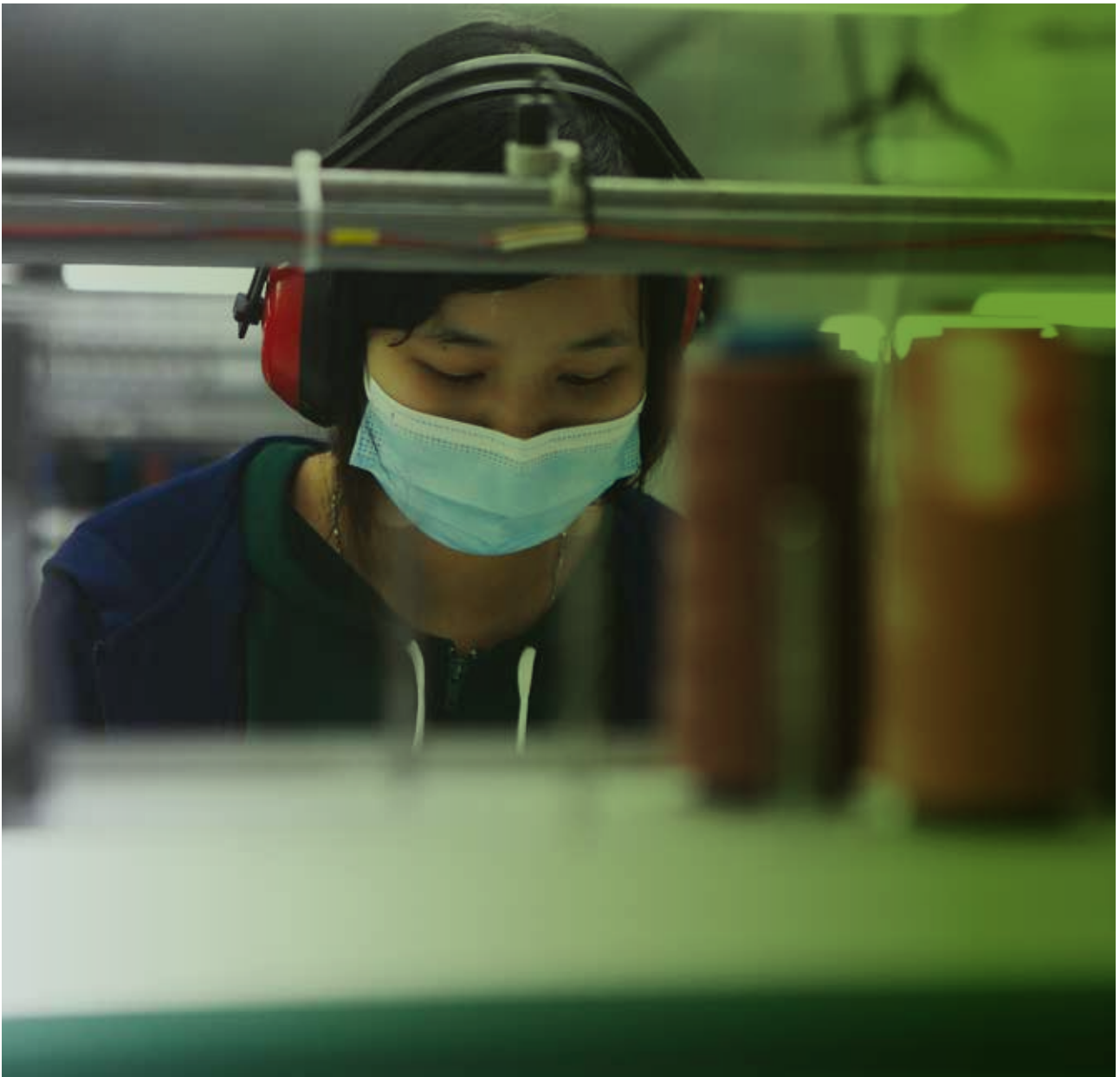
Research published by BWJ in 2020 through large-scale surveys of workers and managers between 2019 and 2020 highlights several main findings.²³

First, significant issues with well-being among workers were found, and their severity varied by gender and nationality. Safety in the workplace, verbal abuse, and concerns with forced overtime were among the working conditions which correlated with mental well-being. Additionally, sexual harassment correlated with lower well-being levels.

Second, financial concerns were found to be linked with well-being, and workers who were the main breadwinner for their families demonstrated the lowest well-being levels.

Third, trust between workers and their supervisors, as well as the availability of family and friends for mental and emotional support, are linked with higher levels of well-being.

A rapid assessment conducted by BWJ between April and June 2021 showed that 15% of the workers surveyed had been infected by COVID-19, and 48% knew someone personally who had gotten COVID-19. As a result of the pandemic, 46% of surveyed workers experienced a reduction in income, 25% a reduction in working hours, and 15% were unable to pay back their loans. A distress questionnaire revealed that 52% of surveyed workers screened for possible mental health issues, and 30% of surveyed workers likely have mental health issues and should be seen by a specialist. Finally, 14% of surveyed workers often or always felt that anxiety or fear interfered with their ability to do things they needed to do at work or from home; 11% often or always had trouble staying focused on tasks, 12% often or always found social settings upsetting, 14% often or always felt hopeless and 22% often or always felt that their worries overwhelmed them.²⁴



3. Methodology

3.1 Approach

The assessment was qualitative and conducted over the following phases:

- 1 Preparation and background research:** IRCKHF started by conducting a thorough review of literature related to the garment industry in Jordan and mental health. The review helped the research team formulate the research tools.
- 2 Tool development:** IRCKHF, in collaboration with the psychologists and mental health experts of the Institute for Family Health – Noor Al Hussein Foundation (IFHNHF), developed the research tools, including the KII and FGD guides. The guides can be found in annex 1. The research tools and ethical considerations were submitted to and approved by the Institutional Review Board (IRB) of Jordan University of Science and Technology (JUST).
- 3 Data collection:** IRCKHF conducted 13 FGDs, 19 IDIs, and 21 KIIs between July and September 2021. While some data collection activities were conducted in person, others (namely IDIs and FGDs with migrant workers) were conducted remotely via Zoom.
- 4 Data analysis and report writing:** a cross-sectional analysis of the data was conducted to interpret knowledge, attitudes, and perceptions across the different participants. Based on the findings, IRCKHF developed recommendations.

3.2 Research participants and recruitment

Three groups of participants were interviewed, including i) external stakeholders, ii) factory management and staff, and iii) factory workers (Jordanians and migrant workers). BWJ collaborated with five factories in the garment sector (exporting, satellite, and subcontracting factories) to be included in the assessment and introduced the IRCKHF team to the management. The coordination that followed happened directly between the factory focal points and the IRCKHF team. The tables in annex 1 provide a detailed breakdown of interviews and focus group discussions.

External stakeholders included 6 interviews with representatives from the Embassy of India, the Embassy of Bangladesh, the Ministry of Health, the Ministry of Labor, the Trade Union of workers in the garment industry, and J-Gate.

Factory management and staff included 15 interviews with factory management, human resource officers, medical officers, dorm supervisors and welfare officers from 5 factories in the garment industry. Individuals to be interviewed were nominated by the factory management based on the characteristics required (role, nationality, etc.).

Interviews and focus group discussions with workers: A total of 81 workers participated in FGDs and IDIs. The factory management nominated participants for FGDs and IDIs based on the characteristics required for each session (gender, nationality, role in factory, etc.). A total of 19 IDIs and 12 FGDs were conducted. Each FGD included 5-6 participants. Different workers participated in FGDs and IDIs.

3.3 Data collection

In-person data collection: some research activities were conducted in person, namely the key informant interviews and the IDIs/FGDs with Jordanian workers. Where activities didn't require a translator, the IRCKHF team conducted the interviews directly. This took place at the location of the key informants, for example, the embassies or ministries, or at the factory.

Remote data collection: research activities with migrant staff or workers who did not speak English required translation. BWJ provided the contacts of two translators who were able to translate English to Hindi, Sinhalese, and Bangla. As the translators were not physically present in Jordan, the research activities were conducted via Zoom. The setup included the workers being in one room in front of a computer screen, the translator in a second screen, and the researcher in a third. After each section or question, the researcher would give the translator the space to translate, listen to the responses and then translate them to English. This process became easier as the factories became familiar with the setup.

3.4 Ethical considerations

IRCKHF takes the ethical considerations that inform data collection, analysis, and dissemination efforts very seriously, especially when it concerns vulnerable groups. To that end, the IRCKHF team was committed to the following ethical guidelines:

- ✓ Participants are treated as autonomous agents
- ✓ Participants must give consent freely and voluntarily
- ✓ Informed consent is documented and is an ongoing process
- ✓ Do no harm policy
- ✓ Privacy and confidentiality of participants is always protected
- ✓ Research is inclusive and with stakeholder consultation
- ✓ Participants are treated fairly and equitably

Specifically for this project:

Informed consent: the objective of the assessment, how the data will be used, and the involvement of the participants were explained to them verbally in a clear way at the beginning of the FGD/IDI. In KIIs, participants provided written consent, and in FGDs and IDIs with workers, they provided verbal consent as most sessions were conducted online.

Confidentiality: All data collected is anonymous and is not linked back to participants. Only the research team has access to the personal data of the participants, and this data was not shared with anyone outside of the research team. The data was only be used for the purposes of this research and to measure the impact of the BWJ mental health project. Participants will remain anonymous, and to protect them against retaliation, no responses are reported individually.

IRB approval: The research tools and ethical considerations were submitted to and approved by the Institutional Review Board (IRB) of Jordan University of Science and Technology (JUST).



3.5 Limitations and challenges

Translation: While the two translators working on this project are highly professional, there is always a possibility of some information being ‘lost in translation.’ This is especially true that the research activities were conducted remotely. The research team worked on mitigating this by probing and asking the same questions differently to ensure that the answers were consistent.

Openness of workers: at the start of every session, the workers were reassured that these sessions were being conducted with the knowledge and the approval of the management, that the information would be confidential, and there will be no repercussions for their participation. The objectives of the research were also clearly stated – with the main end goal of providing recommendations to help support the mental health of workers in the industry. Despite these reassurances, the research team still felt that some workers were reserved in their answers. There was no way to ensure if the management warned or instructed the workers not to share information about mental health distress or suicide cases at the factory.

4. Findings

4.1 Knowledge of mental health problems, causes, and treatment

The assessment explored the level of knowledge around mental health problems, causes, and treatment among workers and stakeholders.

It was found that participants demonstrated varied levels of knowledge around mental health problems and causes. Workers exhibited lower levels of knowledge than stakeholders. The group of workers that demonstrated the most knowledge on the issue was the Jordanian one, especially female workers. While stakeholders have higher levels of knowledge around mental health issues, there are still some groups, especially factory staff, who exhibited limited knowledge on the subject.

While the majority correctly identified that extreme psychological stress from major life events can cause mental health problems, there were mixed opinions on whether biological or spiritual factors can potentially cause mental health problems. Some migrant workers, particularly those from India and Bangladesh, believed that spiritual factors (such as being cursed or possessed) cause mental health problems.

The following sub-sections provide more detailed findings.

4.1.1 Scenarios exploring different mental health problems or disorders

Workers and stakeholders were asked about three scenarios involving an individual exhibiting symptoms of different mental health problems or disorders. Specific symptoms were listed, and they were asked what they thought the individual was going through, what may be the causes, and the best way to treat them. Additionally, a vignette was narrated to workers to see how they reacted to the story and its characters. The following presents the findings from the three scenarios and the vignette.

First scenario: If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? What do you think caused these behaviors? What do you think should be done to help this person?

No workers, except for female workers from Jordan, were able to identify this as ‘depression.’ Male and female migrant workers (from Bangladesh, Sri Lanka, India, and Nepal) were more likely to state the causes that may have led to the symptoms. In other words, when asked what was happening to the person in the scenario, many stated “family issue,” “personal issues,” and “mental tension.” For example, female workers from Sri Lanka stated that the person is thinking of a “serious problem” and male workers from India said that the person is “under excessive tension”. Some workers suggested that the person goes through a physical health issue or sickness.

In most cases, workers attributed the cause of the issue to personal, familial, or financial problems. Jordanian workers were more likely to talk about financial pressure and problems, mentioning debt and the need to provide for children as a source of stress and tension. Some participants stated that the cause of the problem must be identified by talking to the person.

“*Without asking, we don’t know what is happening. There can be a lot of reasons behind this. Maybe she is facing some family issues, maybe it can be family-related issues, maybe issues related to the company or her work, or maybe she had a fight with her friends.’ (Female worker, Nepal)*

Female workers from Jordan were the only ones to identify this case as “depression.” Additionally, they were the most elaborate in the answers they gave. Among the causes that they have listed were personal and family issues such as problems with husband and children, financial issues such as being forced to work and contribute to the income and having excessive debt, or physical health problems such as lack of vitamins and sleep. In one FGD with female workers from Jordan, a reference to faith and religion was made. One participant stated that when someone has faith in God, it is impossible for them to reach a point of depression, because having faith results in feelings of serenity and acceptance.

“*It’s depression. There is no one who has faith in God who could reach a point of depression. When a person is close to God, they know that everything that happens to them is good. They should keep their faith in God and know that anything that happens to them, whether good or bad, is from God and is for God.’ (Female worker, Jordan)*

As for how this person can be helped, no workers suggested referring the person to a psychologist.

Responses varied and included talking to the person to understand what they are going through and offering to support them. Migrant workers, across all nationalities, mentioned resorting to room leaders, welfare officers, and management to support the person, and in an instance where this was identified as a physical health issue, the suggestion was to take them to the “doctor’s clinic.” Workers from Jordan stated other ways to help, including taking the person to the doctor for a checkup, taking a course of vitamins, and taking two weeks of unpaid leave to clear their head.

Half of the stakeholders identified this case as ‘depression.’ This included external stakeholders as well as internal stakeholders, including factory management, human resource, and medical staff.

‘Normally, we say that person is depressed to some extent. It may be for several reasons, maybe for his personal reasons, professional reasons, or a combination of all these factors. Like any other kind of illness, if we have physical problems, we approach the doctor. For mental health also we need to consult with experts in that area and get their help, especially a trained person and professionally accredited people.’ (Embassy of India, representative)

Stakeholders discussed several causes relating to work personal and familial issues. Work issues included work pressure and environment or being poorly treated. Out of 15 management and staff attributed work issues as a possible cause. Personal problems included relationship problems, loneliness, personal loss, and not sharing feelings with others. Family problems could be problems within the household with other family members or problems related to finances and work. One stakeholder mentioned COVID-19 as a potential problem.

Two stakeholders suggested taking the person to a mental health expert or psychologist. Other recommendations included talking to the person and building trust to find out what they are going through, offering moral support in the form of kind words and understanding, talking to management or staff about the problem, keeping the person busy with work, and talking to family or friends. One stakeholder suggested taking them to the doctor but didn’t identify a physician or psychologist, and another stakeholder mentioned giving them annual or sick leave to recover and rest.

‘I would say they are going through, or initial signs of depression. There could be multiple reasons, the person might be sad because of personal loss, or something is not going well in their workplace, family-related issues that they are not able to solve, or financial stress. First, it obviously all depends on how serious the issue is. If it can be helped with moral support or kind words or understanding. If it is more severe, they will need medical help.’ (Factory management)

Second scenario: If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can't focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?

No workers, except for two female workers from Nepal and one female worker from Sri Lanka, were able to directly correlate this case with “anxiety.” Participants from Bangladesh and India were more likely to view the matter as a physical condition. In describing the condition, very few participants were able to draw out a clear connection between the terms “anxiety” and “mental health.” Interestingly, the three who were able to do so were all female. Workers from other countries such as Jordan attributed this case to overthinking certain life problems, and a majority of workers from Sri Lanka attributed it to fear and being scared. In other words, these workers indirectly suggested that the condition was a matter of internal and mental issues. A majority of participants from Bangladesh attributed anxiety to heart conditions such as hypertension, while most participants from India also connected anxiety with being physically sick or unwell. The Bangladeshi and Indian responses, therefore, described this case more as a physical, as opposed to a mental ailment.



In most cases, workers from all nationalities attributed the cause to personal, familial, or financial problems. Sri Lankan participants, in particular, heavily emphasized fear, uncertainty, and being terrified of these issues as the cause of anxiety. Across all nationalities, life pressures were viewed as a significant cause of anxiety. Workers from all countries stated that confronting difficult issues in the home or workplace were significant contributing factors behind this condition. The Sri Lankan participants consistently emphasized terms such as “fear” and “terror” in describing the emotions they feel when confronted with these types of issues. Other common responses included “fatigue,” a lack of sleep, and proper rest. Unsurprisingly, the same Bangladeshi and Indian participants who often described anxiety as a heart condition also viewed heart diseases and heart complications as the main reasons.

Several workers from all nationalities suggested seeking professional medical help. Interestingly, the Bangladeshi and Indian participants who viewed anxiety as a physical condition were more likely to advise professional medical help. However, no participants advised seeking a specialist in mental health issues such as a psychologist or psychiatrist. Several participants from all countries suggested that if a person was facing anxiety, they should seek out a doctor, nurse, or admission into a hospital. The rates of participants advising professional medical help were highest amongst Indian and Bangladeshi workers, which suggests that those who view anxiety as a physical ailment are more likely to view external medical help as the solution. However, across all nationalities, no references were made to specialist doctors or nurses who deal directly with mental health issues. This finding suggests a low level of awareness amongst all workers of these services. Very few advocated seeking religious help in these circumstances.

‘Maybe she has heart disease. I think that they should go immediately to the hospital.’

(Female worker, Bangladesh)

‘He is hyper-tense, maybe he is physically sick...They will take care of him and put him and take him to the doctor, so they have to inform the supervisors.’

(Male worker, India)

In addition to suggesting the need to seek professional medical help, numerous workers from all nationalities showed a willingness to deal directly with that person to help them calm down or relax. Workers from all countries demonstrated feelings of sympathy toward victims of anxiety by suggesting that they would be willing to talk to them to understand their issue, and hopefully make them feel better.

'Most probably the person is really scared of something, and to help him; you need to talk to the person and understand.' (Male worker, Sri Lanka)

Three stakeholders were able to identify this as a “panic attack.” Those included one male factory management representative from India, one female external stakeholder from Jordan, and one male medical officer from Jordan (doctor). Two other stakeholders indirectly made a connection between the scenario and mental health by expressing that sometimes psychological conditions manifest physically but did not explicitly mention a “panic attack.”

'The person is going through a panic attack. I am not an expert; I would say that people who go through depression could have panic attacks. Panic attacks definitely need a medical practitioner to help them with it.' (Male factory management representative, India)

'We have a lot of cases like this. One time, one worker came with a panic attack because she was raped when she was younger. So, in this case, I would recommend giving her Valium to calm her down, but we can't prescribe this here, so we refer them to the hospital.' (Male medical officer, Jordan)

'Maybe she's sick or under excessive tension, and maybe she has a lot of problems and can't tell anyone, and that's why their body is reacting like this.' (Female dorm supervisor, Bangladesh)


Most stakeholders identified this as a physical condition and recommended that a person visits a physician for a check-up. Some spoke of possible physical conditions such as high blood pressure and heart attacks. Among those who mentioned physical conditions, some also stated the possibility of mental health-related problems such as being under extreme distress; however suggested that a physical check-up is required first to rule out physical illnesses.,

“Surely, at first, she needs to go for a physical checkup. If everything is fine physically, then we can look at other matters... If they find it's a complicated case, they should refer her to the mental doctor.” (Male embassy representative, Bangladesh)



Third scenario: If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these behaviors? What do you think should be done to help this person?

A few workers from Bangladesh, India, and Sri Lanka identified this case as a “devil attack” or “ghost attack”. Female workers from Sri Lanka and Bangladesh and one male worker from India stated that individuals can get possessed by ghosts or have “Satan work inside them,” resulting in “strange” and “disturbed” behavior.



‘We have experienced this type of situation, and this person can be suffering from ghosts. In this case, we can’t do anything but take her to the “sick room” and sometimes for spiritual treatment.’ (Female worker, Bangladesh)

‘It’s like a devil attack. There are many workers who think there are ghosts. If you go alone and come back, their mind gets disturbed, so they behave like this. It could be ghost attacks, scaredness.’ (Female, Sri Lanka)

Most workers mentioned mental illness or physical illness as the condition and personal, family or work issues as the causes. As with the previous two scenarios, workers spoke about various personal and familial problems that could occur and place pressure on the individual. Work problems related to work pressure were also mentioned.

‘Because of mental pressure and family and work pressure, one can be acting this way and can have wild behavior like this. This can cause them mental problems.’ (Male worker, India)

Jordanian workers gave different answers, which included autism and childhood problems. Some male and female Jordanian workers (in three interviews) identified in this case as ‘autism.’ Jordanian workers were also the only participants who gave more elaborative responses and discussed issues such as children’s problems, being subjected to violence by parents and in school, sexual harassment, and the sudden death of a close one as possible causes behind the behavior.

‘These are mental illnesses that the person could have suffered since childhood inside and outside the house, like violence at school, neglect by parents, being secluded from others, and so on. (Male worker, Jordan)

‘This is closer to autism. Yes, like a shock. Maybe someone dear to him/her died, or she was subjected to sexual harassment in the street. Maybe it is autism.’ (Female worker, Jordan)

As for the ways in which this person can be helped, only two Jordanian workers suggested consulting with a psychologist. Workers who attributed this to being possessed by ghosts or the devil suggest spiritual treatment, such as visiting a holy man or reciting prayers. Others mentioned speaking to this person, calming them down, taking them to the “sick room,” and consulting with management or a supervisor. Only two workers mentioned that the person should be isolated from others.

‘It could be an illness in the body, like a devil attack or Satan working inside your body or the illness like getting fixed. Or that the person is really scared over something like ghosts or something that others cannot see. In this situation, it is difficult to support, so we get holy men, you have to go to that person and get some oil, they will pray on the oil and apply it on that particular person.’ (Female worker, Sri Lanka)

‘I suggest that he consults with a psychologist. People don’t have to know about it, but he should be convinced to see a doctor. There is no shame in it.’ (Female worker, Jordan)



When identifying this case, some stakeholders discussed psychological causes and conditions, such as past traumas, paranoia, and hallucinations. More specifically, two external stakeholders and one medical officer (male doctor) linked this condition with past traumas that could have been triggered and resulted in this behavior. One factory management representative attributed this to “paranoia” or something working in the subconscious of the person. Finally, one female medical officer (nurse) identified this as “hallucinations,” and one female factory management representative (Jordanian) said that this might be a case of autism.

Some stakeholders suggested that the person is either fearful of something or someone or has a mental illness. One HR manager (Jordanian female) stated that this person could have been subjected to violence or rape, which has resulted in this kind of behavior. Others suggested that the person could be terrified of something or someone and unable to tell others about it.

Other stakeholders identified this case as “being possessed” by a ghost or spirit. Specifically, this was stated by a female welfare officer from Bangladesh, a male dorm supervisor from Bangladesh, a female HR manager from Malaysia, and a factory management representative from Jordan. The latter two said that this was a common belief among certain people, but it is not necessarily their own belief.

‘Sometimes it can be that she is possessed by the ghost. If that person can speak, they would talk to her and see what is happening with her. If she isn’t, they can go for spiritual treatment like reciting Qur’an and sometimes give her sick leave.’

(Female welfare officer, Bangladesh)

‘I have one Burmese worker. In her religion, she is not allowed to eat beef, but unfortunately, she ate it by mistake. When she realized she had eaten the beef, she started shaking, and she said that it was the evil spirit inside her because she had eaten it. Because we have the translator, they know the Burmese culture very well, so we helped her in a religious way.’

(Female HR Manager, Malaysia)

Two stakeholders mentioned that this could possibly be done to seek attention. These included an external stakeholder and a former union representative. They explained that they had experienced situations where workers pretend to be going through something extreme like this so that the management has no choice but to send them back home.

“*Sometimes, she doesn't want to continue working at the factory and wants to go to Bangladesh, but the company won't let her go because of the contract. Sometimes the worker will misguide the management and act like this so that the management sends her back home... This doesn't often happen, just a few people. Maybe her husband said if you don't come back in seven days, I will marry another woman. So, she does this to leave in seven days.*”
(Female former union representative, Bangladesh)

Several stakeholders suggested sending the person to a mental health expert or doctor. These included two external stakeholders (embassy representatives), one medical officer, and one management representative. Those who attributed this to “spiritual” reasons suggested “spiritual treatment,” and others recommended that the person should be calmed down, talked to, and after that treatment could be identified.

Vignette: Ahmad and Kareem are roommates. They are construction workers on a site in a remote location. Their work is physically tough, as they must work for more than 8 hours a day under the heat. Ahmad and Kareem are also away from their family and only get to visit their wives/children every two years. Ahmad has been noticing that Kareem's behavior has been changing for months, especially after he found out that his mother has a bad case of COVID-19 back home. At first, Kareem stopped engaging and talking to people around him. Then Ahmad noticed that Kareem talks to himself sometimes and catches him staring at the wall for long periods. Two months later, Kareem's behavior kept changing. Ahmad was worried about his roommate and friend, so he sat with Kareem and asked him what was happening with him. Kareem said that he hears voices in his head. The voices often tell Kareem that ‘there is no point’ and that Kareem should ‘end his life’ to find peace.

Some workers attributed what Kareem is going through to mental stress, depression, mental pressure, and mental exhaustion, while others referred to his behavior as weird, crazy, and disturbed. A few workers from Bangladesh, India, and Sri Lanka used the terms “crazy behavior” and “crazy situation” to describe what Kareem is going through in the story. None of the workers from Nepal or Jordan used the word “crazy.” Workers from Sri Lanka and Jordan were the only ones who referred to depression (both) and anxiety (only Jordanian workers).

All female and male workers across nationalities, agreed that the main reason behind Kareem’s situation is his worry over his mother and his inability to visit her. Some workers added that the combination of certain factors, such as being away, being unable to travel, being forced to work to provide for the family, and being homesick, all contributed to exacerbating Kareem’s situation. Some migrant workers sympathized with the story and reflected on a personal level:

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‘I almost had a similar incident because my mother was COVID-19 positive, and I was in a very stressful situation. I was busy and had to work. I wanted to go back home but couldn’t. I was in a different country, and there were so many restrictions on traveling. I did not eat, I was very upset, but I was strong. I knew I had to pass this through.’
(Male worker, Sri Lanka)

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‘Due to COVID, the same happens to us. Because of his mother’s sickness, he is acting like this. We must make him understand that this pandemic is facing the entire world and not only him. We have to support him and make him understand that everyone is going through this even if he can’t go home.’
(Male worker, Nepal)

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‘My mother passed away, I missed her mother and couldn’t see her, so I was feeling upset and was behaving like this as well.’
(Female worker, Bangladesh)

4.1.2 Causes of mental health problems

Most male and female workers, across all nationalities, agreed that extreme psychological stress facing major life events, such as the death of family members or moving to a new country, can cause mental health problems or disorders. Most workers explained that such events cause “mental tension and pressure.”

‘It is a situation where you can’t really leave your mother and father, but because of the context, you have to leave, so this is like a major shock in your life. So, in this case, you will have a mental illness.’ (Female worker, Sri Lanka)

Very few workers gave different responses. For example, in one FGD with male workers from India, participants explained that this depends on the person, his/her personality, and how close he or she is to the family. In another FGD with male workers from Nepal, participants said that everyone goes through problems, and this doesn’t mean that these problems must result in mental health issues. In a few instances, workers reflected on their personal experiences and situations. One male worker from Nepal described what would happen to him if something were to happen to his parents:

‘If anything happens with my parents or happens to my family, it will impact my brain, and it will become an issue. I will not eat, and I will keep thinking of them and so on.’ (Male worker, Nepal)

Another female worker from Sri Lanka shared her story and explained how only having her mother living in Sri Lanka impacts her:

‘I only have my mother. I am not married, even though I am past 30. If something happens to my mother, I might end up in a situation like this because I won’t have anyone to live for, I don’t have anyone to think about, I am alone, I am scared, I am lost in this world. Maybe I will get sick.’ (Female worker, Sri Lanka)

The majority of stakeholders agreed that extreme psychological stress could cause mental health problems or disorders. Some explained that this is particularly true for migrant workers who are away from their families and face several challenges such as homesickness, language barriers, culture shock, and financial issues.

‘Sure, this happens and is the main reason workers suffer. I once saw one worker, she worked for four years and used to send all her money to her husband. Then one day, she gets the news that her husband is marrying her sister and her parents approved of that. When she got that news, she wanted to commit suicide, and she was out of control.’

(Female former union representative, Bangladesh)

Other stakeholders said it depends on the person, their personality, and how they cope with problems. These included two external stakeholders and one HR officer. They explained that some people are more susceptible to being affected by life events. Two stakeholders said that such life events do not cause mental health problems.

‘It differs from one person to another. Some people under stress become like machines and stop having emotions; others have childhood memories that are triggered. I think there are many sides to this. I am not a mental health professional, but I know that the psychology of people differs.’

(Female external stakeholder, Jordan)



Male and female workers had mixed opinions on whether or not mental health problems or disorders may occur as a result of spiritual factors, like being cursed or possessed. Some differences across nationalities were observed.

Nearly all workers from Bangladesh and India agreed that mental health problems or disorders might occur as a result of spiritual factors, such as a person being cursed or possessed by a ghost. Only one male participant from Bangladesh and another one from India said that even though people from their countries believe in these factors, they do not, but rather believe that these disorders come from a 'weak mentality'. Some said that they believe that some circumstances can lead to someone being cursed.

'For instance, if people go to certain places alone at certain times, with their hair shown or in the afternoon or the nighttime this can lead to problems.' (Female worker, Bangladesh)

Workers from Nepal and Sri Lanka gave mixed responses. All but one worker from Nepal did not believe that mental problems or disorders can be caused by spiritual factors. As for workers from Sri Lanka, answers varied. Some workers believed that mental problems or disorders may occur as a result of spiritual factors, while others did not. One male worker from Sri Lanka said that these factors play a role only if you believe that they do.

'No, it is just a lie. It is a fake thing. Mental health-related issues only happen with regards to your mind and health, nothing regarding spiritual issues.'

(Female worker, Sri Lanka)

'Those could be reasons, but it depends on your faith or what you believe in, if you think that those are not reasons then it will not affect you, but if you start believing that things like that exist, it can cause you mental health problems.'

(Male worker, Sri Lanka)

As for workers from Jordan, answers were also mixed as some believed in spiritual factors and have heard of people who got treated by going to a Shaikh, while others said that they do not believe in it. Some said that they don't per say, but that it is mentioned in the Quran so they cannot disregard it.

'We had so many cases like that in the factory, while we worked a migrant worker for example started screaming and banging her head on the machine. One time they caught her cutting herself, and they said that their dorm was possessed and got her a Shaikh to read on her. They kept putting Quran in the dorm, and also in the factory and they stopped the songs for a while until things settled down' (Female worker, Jordan)

All stakeholders interviewed agreed that nearly all migrant workers and some Jordanian workers believe that mental problems or disorders may occur as a result of spiritual factors, such as a person being cursed. Some stakeholders emphasized that mental problems or disorders may occur as a result of spiritual factors only if the person believes it will.

'I personally don't believe in that, but it happens in the garment sector, actually I was responsible for this when I worked in factories. We used to handle this type of issue. 99.9% of workers believe that this happens because of Jinn or ghosts or something like that. This happens a lot during the winter season.' (Female former union organizer, Bangladesh)

'If you are a very strong believer when something like this happens, yes. When you see someone practicing something that scares you. If you are a strong believer, then yes.'

(Male factory management representative, India)

Some stakeholders also said that a way to deal with these beliefs and to make patients feel better is to accept them. These included two external stakeholders and three internal stakeholders (management representative, medical officer, and dorm supervisor). As a way of dealing with such issues, some factories set up shrines for workers, or they take them to spiritual healers, and they end up feeling better as a result.

“Today, I saw two cases. Frankly, for me, the most important thing is the patient, regardless of the road to recovery. The workers wanted to see a healer, we call him Sheikh or Al-Mulla, so I said yes. I told them it was normal, let us learn, leave them to their affairs and let them treat them. They returned to work totally better. They just felt better and returned to work a hundred percent.” (Male medical officer, Jordan)

Workers also had mixed opinions on whether mental health problems or disorders may occur as a result of biological factors such as genetics. Only workers from India agreed that biological factors do not result in mental health issues at all. However, workers from Bangladesh, Nepal, Sri Lanka, and Jordan had mixed answers. Some workers said that biological factors and genetics play a huge role in mental health, just like it affects our physical health, while others disagreed.

“Yes. Just like we inherit physical stuff and diseases. If someone is angry, it’s possible the child is angry too.” (Female worker, Jordan)

“It’s not like a virus; it can’t be passed. It’s only the person who has mental issues that are affected, only this person.” (Female worker, Bangladesh)

Some workers said that they do not have knowledge regarding the subject, while others said that there might be a relation. Still, they are not sure of the percentage of cases of mental health disorders that were affected by biological factors.

‘I think the probability of getting it from genetics is less; it’s 50%.’ (Female worker, Sri Lanka)

The majority of stakeholders agreed that mental health problems occur as a result of biological factors, and some gave a few examples.

‘We had a case of two sisters, and their case was difficult to identify. We contacted their mother, and she told us that there’s a family history of mental illness. Through a course with Better Work, they helped us diagnose it as a case of psychosis, and that way we were able to deal with the worker much better.’ (Female welfare officer, Jordan)



Some stakeholders said they do not think biological factors play a role in mental health, while a few said they do not know or are not sure about it. One participant said that it is a combination of both genetics and life experiences and that workers have to be prepared to be more resilient in their mentality and have the knowledge to face such challenges.

‘Both, if you have a family history, then most probably you have the genes for it, but logically everybody has mental health issues. It mostly depends on your education and how resilient you are. Most of us are affected, but some people can come out of it quickly. They say they don’t have mental health issues, they do, but it’s just that their resilient power is more. So, what we need to do for this mental health project, is for the workers to have the resilience power to come out of the problem. we can’t solve the problem; we need to prepare ourselves to face the challenge’
(Female HR manager, Malaysia)

4.1.3 Discussion: knowledge of mental health problems, causes, and treatment

Mental health literacy is defined as ‘knowledge and attitudes about mental health conditions (MHC) which aid their recognition, management, and prevention.’²⁵ Research shows that while many people worldwide typically have considerable knowledge about the causes and prevention of major physical health problems, such as cancer and cardiovascular diseases, knowledge about mental disorders has generally lagged behind.²⁶ Mental health literacy is low worldwide; but particularly lower in developing countries.²⁷

For example, an assessment of awareness of MHC conducted in a rural district Bangladesh with 2,425 adults (aged 18–90) found that 3.4% of respondents were aware of all three common MHC (depression, anxiety, and drug addiction). Only 1.3% were aware of all three severe MHC (psychosis, dementia, and bipolar disorder). Among those who were aware of at least one MHC, only 9 and 6 respondents reported that they had suffered common and severe MHCs, respectively. The level of awareness was found to be higher among males and respondents with higher levels of education.²⁸

Another example from Sri Lanka is the 2007 National Mental Health Survey. In response to a number of vignettes, respondents were able to identify that the characters in the vignettes were suffering from a psychological condition. Still, very few were able to label the condition or identify the type of mental disorder. As for the causes, most respondents stated that the conditions in the vignettes were due to external factors such as physical or financial problems.²⁹

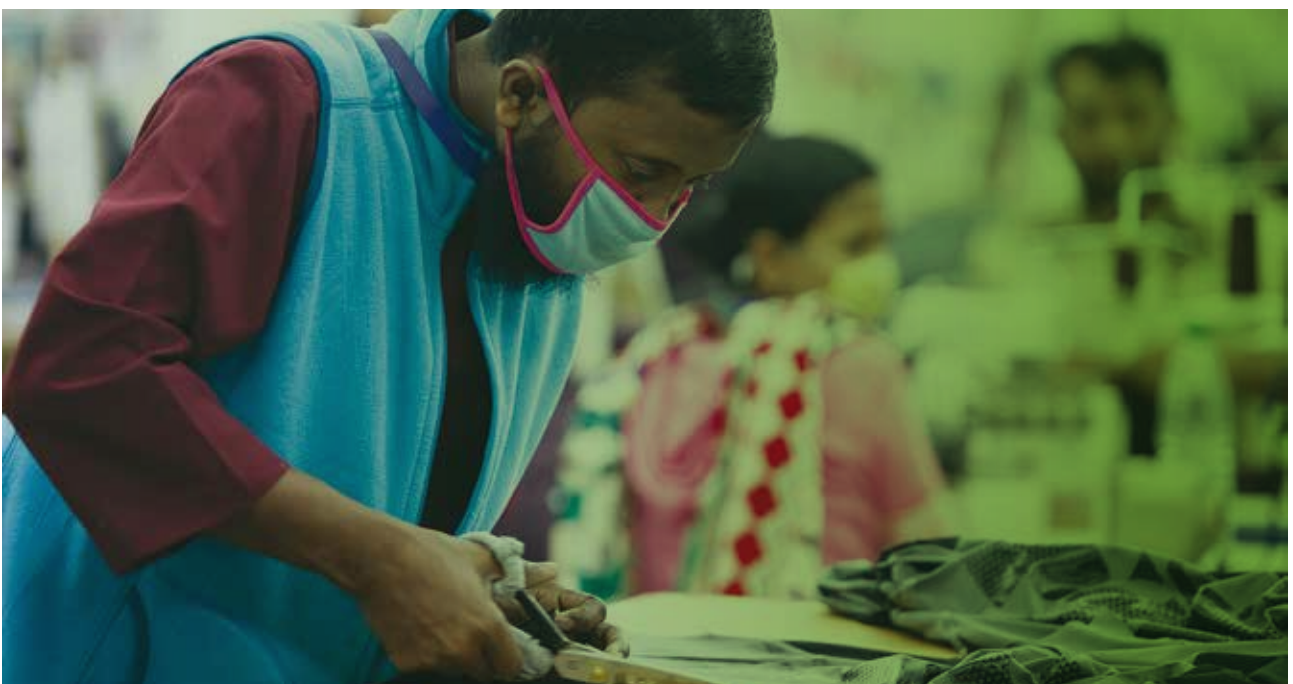
In line with previous research, the findings of this assessment suggest that there are low levels of knowledge among workers in the garment industry on what mental health means and what it can encompass. The group that demonstrated the most knowledge on the issue was Jordanian workers,

especially female workers. While stakeholders have higher levels of knowledge around mental health issues, there are still some groups, especially factory staff, who exhibited limited knowledge on the subject.

The majority of workers and stakeholders agreed that extreme psychological stress facing major life events, such as the death of family members or moving to a new country, can cause mental health problems. Workers had mixed opinions on whether mental health problems or disorders may occur as a result of spiritual and biological factors. Looking specifically at spiritual factors, such as being cursed or possessed, nearly all workers from Bangladesh and India agreed that they could be the cause of mental health disorders. Workers from Nepal, Sri Lanka, and Jordan gave mixed responses.

Spiritual and religious factors and their association with mental health problems have been explored in previous research. In some cultures, mental health conditions are associated with being possessed by spirits and demons, sorcery or spiritual punishment, and social or moral disobedience towards ancestors or gods.³⁰ A study on the stigma towards people with mental illness in developing countries in Asia found that supernatural, religious, and magical approaches to curing mental health illnesses are prevailing.³¹

Research on mental health in India looks at different socio-cultural factors impacting attitudes toward mental illness and treatment-seeking. The study demonstrated that as the traditional Indian family values consider family members capable of solving all problems, this results in the sense of shame when seeking help from ‘outsiders,’ in turn limiting mental health treatment-seeking. However, when treatment is sought from sources outside the family, it is often sought in temples and from religious leaders. As there is a belief in supernatural causations of mental health illnesses, such as the curse of God and evil spirits, many tend to believe in magical cures by religious leaders and faith healers.³²



A case study on a Tibetan tribe living in a north-central region in Nepal found that one of the most common forms of illness is a malady that can be translated to ‘spirit loss,’ a state in which one of the ‘life-forces’ or ‘spirits’ departs from the body. In some cases, a sudden fright causes this spirit to leave the body and wander around. When the spirit leaves, a person loses the volition to act in life: the body feels “heavy,” lacks energy or “passion,” and the afflicted person does not care to eat, talk, work, travel or socialize. Thoughts become “dull” and unbalanced. The person can also have trouble sleeping is prone to further illness.’ When a member of the tribe suffers from this illness, a shaman is usually summoned to conduct a healing ceremony that includes sacred chants.³³

Finally, there was very little mention of work-related conditions as being a cause of mental health problems for workers in the garment industry. Research conducted in 2019 by BWJ found that there are overarching factors that can adversely impact the mental health and well-being of migrant workers in the garment industry in Jordan, including workplace conditions, living conditions, personal factors, and gender dynamics. Workplace conditions included repetitive work, high psychological job demands, short acclimation periods, and lack of information about work conditions which result in depression, loss in self-esteem, and exacerbates existing stressors from the migratory experience. Living conditions, on the other hand, included high population density in dormitories and lack of personal space, poor living conditions including accommodation cleanliness and lack of protection against diseases which result in elevated levels of psychological distress.³⁴ In this assessment, it is possible that workers did not mention work and living-related conditions as causes of mental health distress in fear of harming the reputation of the factories and the possible repercussions that they may face if they do.

Lack of knowledge around mental health problems and causes is problematic because it impacts the way management and staff interpret and diagnose mental health problems and, in turn, provide the proper course of treatment as well as the willingness and responsiveness of workers to seek or accept the correct treatment.



4.2 Perceptions of mental health problems and solutions

As part of the assessment, questions explored the perceptions of participants around mental health and individuals suffering from mental health issues. **Previous research shows that there are several myths associated with mental health**, some of which are: that mental health is caused by personal weakness; mental health conditions are not curable and that people with mental health are violent or unstable.³⁵

This assessment finds that there are negative connotations associated with mental health and those suffering from mental health issues. This was evident by some of the words used by workers and stakeholders to describe individuals going through mental health problems, including “anger”, “difficulty in dealing”, “crazy”, “insane,” and “disturbed”. Furthermore, **there are differences across nationalities in the way workers perceive mental health issues and causes.** Among notable differences was the issue of religion and faith, which was only brought up by Jordanian workers who believed that individuals who have faith in God are less likely to go through severe mental health issues. Another difference is the strong belief in spiritual causes, such as being possessed by ghosts or the devil, which was expressed by some migrant workers.

The following sub-sections provide more detailed findings.

4.2.1 Perceptions of mental health

Workers and stakeholders (external stakeholders, factory management, and staff) were asked about the first thing that comes to mind when they hear the term ‘mental health’.

Most male and female workers across all nationalities were unable to elaborate on the term. Many used the word “mental” to describe “mental health.” When asked to expand on these descriptions, they often associated “mental health” with terms such as “tension,” and “mental problems” and saw financial, family, and work issues as causes that might lead to these issues.

Jordanian workers were most able to elaborate on the meaning of “mental health.” Phrases such as “happy” and “relaxed” were regularly used by this group, and several others described how mental health means an absence of problems or pressure in life. A couple of Jordanian participants also referred to the environments around them as factors that might affect mental health. Interestingly, more than one Jordanian participant differentiated between mental and physical health.

‘To be happy from the inside, is more important than physical health.’ (Female worker, Jordan)

Looking at some differences, workers from Sri Lanka in particular associated “mental health” with “freedom.” Workers from Bangladesh, on the other hand, were the least familiar with the term as most of the participants from this group claimed to have never heard the term or were confused by the question. The translator, also from Bangladesh, explained that this phrase is not a part of the language.

‘It leads to freedom. No family issues, no financial problems, everything is good around. It all goes around freedom.’
(Male worker, Sri Lanka)

‘We never heard this word before; we know the word mental problem. Mental health we don’t know.’
(Female worker, Bangladesh)

When asked about the first thing that comes to their mind when hearing the words ‘mental health,’ some stakeholders referred to positive aspects of mental health, such as “stability,” “seeing things clearly,” “being in control,” and “being relaxed.” One stakeholder (HR manager) explained how her perception of mental health changed. Before attending seminars, she used to associate mental health with “craziness”, but now she associates mental health with being “free from anxiety and worry” and being able to challenge problems and circumstances.

‘The overall stability of a person; so, if that person is stable and can have the right frame of mind, they can think easily and won’t have any kind of problem, they are mentally stable.’
(Embassy representative, male)

A few stakeholders provided responses with negative connotations. Their responses included “anger”, “difficulty in dealing” and “mental disturbance”. One mentioned that married women are most susceptible to mental health problems because they face pressures related to husbands, children, and finances.

Some stakeholders spoke about work-related aspects. These included two external stakeholders and four internal stakeholders (one factory management representative, two HR officers, and one medical officer). Some associated being happy or comfortable with higher productivity and better work. Others referred to the need to create a comfortable and decent work environment to ensure good mental health.




‘Mental health means clarity. Keeping workers’ minds fresh so that they can function and work. We have welfare officers; they have open discussions with workers.’ (Factory management, male)

‘People should be relaxed. Mental health means when I am relaxed mentally, I’m fresh, and my work is good.’ (HR manager, male)




Slightly over half of the workers think that exercise, rest, good living conditions, and having a support network are enough to contribute to good mental health. Slightly over half of the total workers across all nationalities believed that exercise, rest, good living conditions, and having a support network (friends and family) were sufficient to ensure someone's mental health. This finding suggests low levels of awareness of the reality that mental health issues can still arise for people who live comfortable and seemingly healthy lives. There were no noticeable differences between answers provided by male and female workers.



'It's impossible to have a mental health problem in that case. If you have all of this, you can't suffer from mental health. These will make mental health better.'
(Female worker, Nepal)

Jordanian workers were most likely to expand upon the given factors and often stressed how additional considerations such as religion or finances were also important considerations. While a majority of Jordanian workers answered "yes" to this question (are exercise, rest, good living conditions, and having a support network enough to contribute to good mental health?), they were most likely to add to and provide details to the given list of factors. One participant emphasized the importance of religion in preserving mental health and proceeded to suggest that faith was the most important factor in solving mental health issues. Several Jordanian respondents also emphasized the importance of financial stability and a good salary to ensure mental stability.



'In our religion, Islam, if you have a problem, you can pray and put your faith in God. This will give you serenity. But for an atheist, how will you solve their problems?'
(Female worker, Jordan)

All Sri Lankan workers stated that these factors were not enough to ensure mental health, which suggests their higher level of awareness regarding the myriad risk factors behind mental health dilemmas. Interestingly, all Sri Lankan workers answered this question with “no” and claimed that exercise, rest, good living conditions, and having a support network (friends and family) were insufficient for preserving one’s mental health. While several explained that these factors might help in alleviating a mental health problem and preventing “extreme” situations, they all stressed that people in these situations were still susceptible to mental health problems. This finding indicates that Sri Lankans are most aware of the reality that mental health issues can arise for a variety of reasons and may still be present in individuals who lead seemingly comfortable lives.

‘It may help maybe stop you from getting into an extreme situation. But even if everything around you is good, you can still have mental health problems. It just takes a second.’ (Male worker, Sri Lanka)

‘If you are a person with all these things, still do not have control over heart or mind. Still, you can have mental health-related issues. Even though you have everything, you can still have mental health problems.’ (Female Worker, Sri Lanka)

4.2.2 Perceptions of individuals going through mental health problems

Workers were asked two questions regarding the characters in the vignette below.

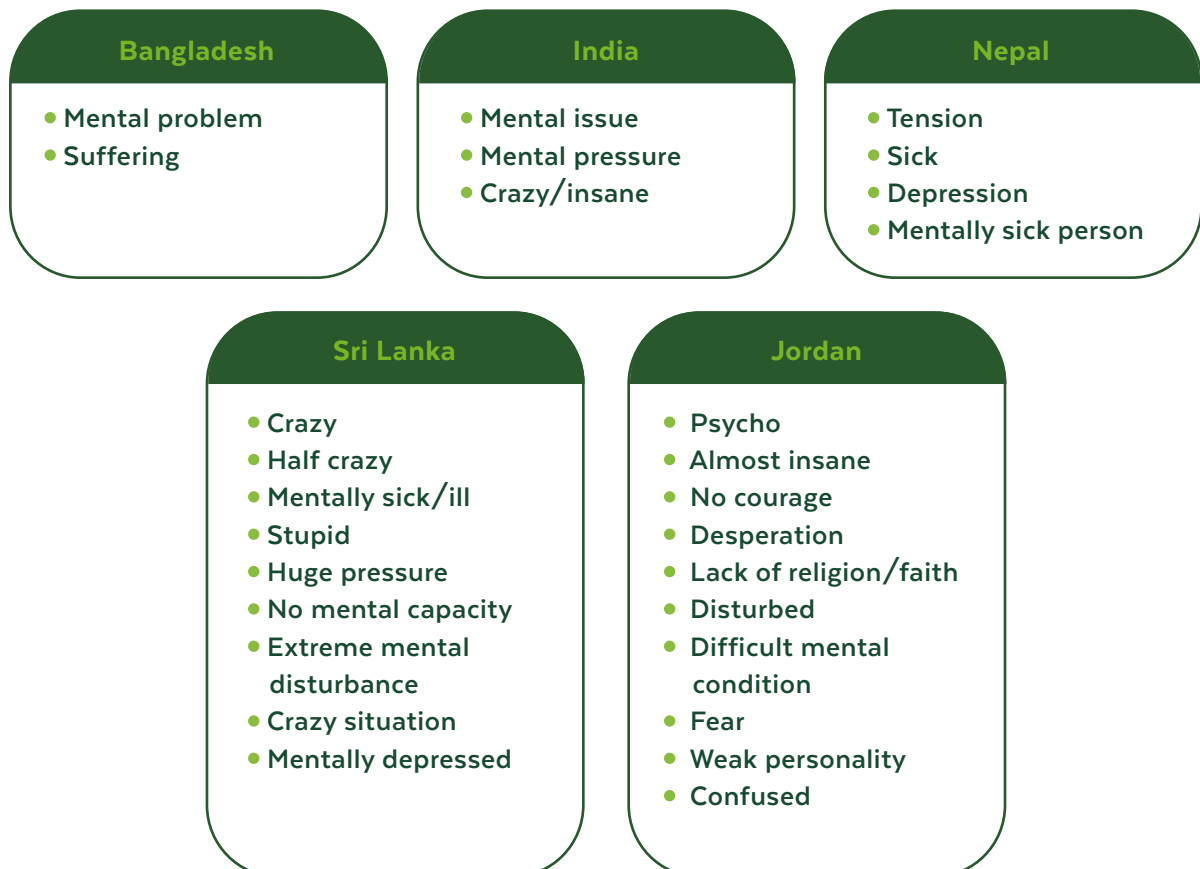
Vignette: Ahmad and Kareem are roommates. They are construction workers on a site in a remote location. Their work is physically tough, as they must work for more than 8 hours a day under the heat. Ahmad and Kareem are also away from their family and only get to visit their wives/children every two years. Ahmad has been noticing that Kareem’s behavior has been changing for months, especially after he found out that his mother has a bad case of COVID-19 back home. At first, Kareem stopped engaging and talking to people around him. Then Ahmad noticed that Kareem talks to himself sometimes and catches him staring at the wall for long periods. Two months later, Kareem’s behavior kept changing. Ahmad was worried about his roommate and friend, and so he sat with Kareem and asked him what was happening with him. Kareem said that he hears voices in his head. The voices often tell Kareem that ‘there is no point’ and that Kareem should ‘end his life’ to find peace.



First, workers were asked about adjectives that they would use to describe the character of Kareem. Figure 1 summarizes responses per nationality.

Some of the words used included “mental problem”, “mental issue”, or “illness”, while others were more negative and included “crazy,” “insane,” and “disturbed.” Jordanian workers made another reference to religion, stating that Kareem’s behavior is a sign of a lack of faith.

Figure 1 – Adjectives/words used to describe ‘Kareem’ (Vignette)



Second, workers were asked whether they thought the character of Kareem was dangerous.

Workers were almost equally split in their opinions on whether Kareem is dangerous. Almost half of the workers believed that Kareem was dangerous, as he reached a point of hearing voices in his head. Some also explained that if Kareem is capable of ending his life, he might be capable of hurting others around him. The other half stated that he is not and added that while he could be a danger to himself, he is not a danger to others.



“
‘Kareem is not dangerous as he is not doing anything harmful to others. He is not hitting or shouting or attacking anyone.’

(Female worker, Bangladesh)

“
‘Kareem is thinking about taking his own life, which means he can take any other life. In that case, Ahmad is in danger now.’

(Female worker, Nepal)

“
‘Yes, he could be because he is already getting sounds from his mind regarding suicide, so he might get other sounds in his head, so it seems like a bit of a terrifying situation.’

(Female worker, Sri Lanka)

In a separate question, workers were asked whether they thought strong and healthy individuals could still have mental health problems, to which nearly all participants across nationalities agreed.

Almost all workers believed that there was a difference between external and internal health. In other words, they claimed that people who appear physically strong might still be dealing with mental health problems. Common responses included “anything can happen” or “can happen to anyone.”

“
‘Mental problems have to do with our minds, and they can affect our minds and not our physical health. It can be happening to anyone.’

(Male worker, India)

“
‘Yes, even though your body is healthy, problems can attack your mind or your heart or spirit.’

(Female worker, Sri Lanka)

Jordanian workers were the most likely to say that people suffering from mental health problems should continue to work, emphasizing how doing so might provide a beneficial distraction from their problems. More than half of Jordan workers believe that those suffering from mental health problems can work. Some clarified that it depends on the severity of the issue and stated that additional supervision might be needed in these cases. Most importantly, nearly half of Jordanian workers claimed that working might actually improve their condition and help these people by helping them to socialize and take their minds off of whatever is bothering them. In other words, continuing to work and being around others was viewed as part of the solution to address mental health issues.



'Yes, must see people and socialize to get better.'
(Female worker, Jordan)

'Has to work to change mental state and see people. Better than sitting alone.'
(Male worker, Jordan)

“

“



Most workers from Bangladesh, India, Nepal, and Sri Lanka suggested that these people should not work as doing so presents heightened risks to themselves as well as those around them. However, their explanations for these responses tended to vary. Contrasting the more sympathetic Jordanian responses, a majority of workers from Bangladesh, India, Nepal, and Sri Lanka did not believe that people suffering from mental health problems could or should work. Certain participants claimed that if a person were mentally unwell, the quality of their work would be diminished. In contrast, others argued that placing oneself in a difficult work situation would only exacerbate the problem and create issues for those around them. One woman from Bangladesh claimed that if she did have a mental problem, she would not share it with her management out of fear of losing her job. Thus, the widespread negative views toward people with mental health issues in the workplace, coupled with this anecdote, suggest that there is still a taboo around mental health in the workplace that has not been adequately addressed.

“If I keep this to myself, I can work, but if the company knows about my sickness, they will not keep me.”
(Female worker, Bangladesh)

“Cannot work because he’s not mentally sound, even the cleaning, how he will do that?”
(Male worker, Nepal)

“No, they can’t work because they will create problems for other workers.”
(Multiple Male workers, India)

4.2.3 Discussion: perceptions around mental health

Previous research shows that there are several myths associated with mental health.³⁶ Such myths, along with certain social, cultural, and religious beliefs, are barriers to seeking help.

A study on the stigma towards people with mental illness in developing countries in Asia found that people with mental illness are considered aggressive and dangerous and tend to be socially excluded as a result. It also found that supernatural, religious, and magical approaches to curing mental health illnesses are prevailing.³⁷

The findings of this assessment show that there are differences across nationalities in the way workers perceive mental health issues and causes. Among notable differences was the issue of religion and faith, which was only brought up by Jordanian workers who believed that individuals who have faith in God are less likely to go through severe mental health issues. Another difference is the strong belief in spiritual causes, such as being possessed by ghosts or the devil, which was expressed by some migrant workers.

Additionally, in line with previous research, this assessment finds that there are negative connotations with mental health and those suffering from mental health issues. This was evident by some of the words used by workers and stakeholders to describe individuals going through mental health problems, including “anger”, “difficulty in dealing”, “crazy”, “insane,” and “disturbed”. This was confirmed by stories cited by workers about individuals going through mental health problems and how they were treated in their communities.

The differences in perceptions of mental health issues and causes greatly impact the extent to which mental health patients are willing to disclose or talk about their mental health problems, their willingness to seek help, and their inclination to accept medical treatment. Those who are in an environment or community that stigmatizes mental health issues are less likely to be open about their mental health issues. Furthermore, negative connotations with mental health and individuals going through mental health problems will likely impact how management, staff, and workers treat those suffering from mental health issues, increasing the likelihood of exclusion and stigmatization.

4.3 Attitudes towards seeking help

The assessment explored workers’ attitudes toward seeking help when faced with mental health issues. The examples they were given included feeling sad, anxious, stressed, or lonely.

Several factors impact the likelihood of workers in seeking help as well as the type of help they seek. Barriers to seeking help from factory management and staff include i) the fear that problems will become bigger and more exposed, resulting in the spread of rumors; and ii) fear of jeopardizing their jobs. However, those who stated that they would seek help from factory management and staff stated that factory management and staff tend to have solutions to problems. Many workers stated that they would confide in friends with personal problems as friends can be trusted in keeping problems private.

The following sub-sections provide more detailed findings.

4.3.1 From the perspective of workers

If faced with a mental health issue, most male and female workers across all nationalities stated that they would seek help from factory management or staff. Most workers said they would resort to factory management, supervisors, welfare officers, or doctors if they were going through a mental health issue such as feeling sad, anxious, stressed, lonely, etc. The reason behind this, as explained by the workers, is that management and staff can offer solutions.

“Yes, with my supervisor or with the doctor. If my mental health issue can be solved by my supervisor, then no need for the doctor, but if it needs a doctor, then I have to go to the doctor.”
(Female worker, Bangladesh)

“If we are faced with something like this, we will contact management and welfare officer, not a friend. Usually, management can give solutions while friends can’t.” (Female worker, Nepal)

Many workers also stated that it depends on the problem, whether personal or work-related, and accordingly would turn to friends or factory management and staff. For many male and female workers, seeking help is dependent on the problem. Some prefer confiding in friends if it was something personal or family-related but would go to their supervisors or welfare officers if it was a work-related problem. Others stated having no issue with resorting to friends or supervisors at any point.

'It depends on the reason behind my sadness; if it were because of work, then I would share it with my supervisor and manager. If it was a personal issue, family issue, or a secret, then I would share it with my friends.'
(Female worker, Nepal)

'It depends on the problem; if it is personal, then I will try to solve it myself. If it is related to my health or mental health, then I will definitely go to the doctor. If it is related to work then, I will go to my supervisor.'
(Male worker, India)

A few workers stated they would not resort to factory management and staff at all. For a few male and female workers from Sri Lanka, Jordan, and India, seeking help from factory management and staff is not an option because some fear that problems will become even bigger, and others prefer to keep problems personal. For a few workers, not speaking out to management or even friends stems from the worry of rumors spreading about them and their problems.

'Not management because I prefer to keep problems personal won't speak to anyone other than my friend. I currently have 2 or 3 different problems, but I prefer only to talk to my closest friend because they are personal problems.'
(Male worker, Sri Lanka)

'We will not talk about it because sometimes in the factory, if you talk about your problems to others, the news will spread, and your problems will become like common talk among everyone. So, unless we really trust the person, maybe we would speak up.'
(Female worker, Sri Lanka)

4.3.2 From the perspective of stakeholders

Almost all factory management and staff members who were interviewed agreed that a worker exhibiting signs of mental distress should be referred to a doctor. However, some stated that it would be reasonable to talk to the worker first to understand what they are going through, and then refer them to the doctor if any serious problems are detected. Many indicated that welfare officers are usually the best focal points to have conversations with workers about their grievances.

‘Some people just want comforting, they need to express their feelings more freely, we have people who they can talk to, and if after they talk, they feel good, then that’s good enough. But if that was not enough, obviously they need medical help because not all medical issues can be solved through counseling; it may require medication through a doctor’s help.’

(Male factory management representative, India)

Almost all factory management and staff members who were interviewed believed that workers who are going through mental health distress have to be treated with understanding and support. Participants spoke about different ways to support workers who are going through mental health problems, including talking to them and understanding their problems, giving them some time to rest, and checking on them. No participants stated the need to be additionally strict with workers who are going through problems, and one emphasized that a balance should be maintained.

‘It varies from person to person. When I see someone, I can easily understand if they have mental problems. Sometimes I offer one or two days of leave. If I found that there is no physical illness, no issues related to work, no issues related to family, but I find that she needs sound sleep, needs some food, some time to enjoy. That I arrange. I talk to the department; I give one or two days. I send them to sleep, I get them fruits, and I ask the welfare to take her in the evening for a walk outside. They feel different.’ *(Male HR manager, Bangladesh)*

‘If somebody is suffering from mental health issues, it’s not a disease that is contagious, so we should not treat them differently. We should support them, talk to them, and help them come back to normal life.’ *(Female dorm supervisor, Bangladesh)*

‘Strict is not good. The balance between work and freedom. Force doesn’t work.’

(Male factory management representative, India)

4.3.3 Discussion: attitudes towards seeking help

Beliefs around the various types of professional help and their benefits are important to understand the likelihood and willingness of patients to seek help. Research shows that if a person with a mental health disorder believes that consulting a mental health professional is unlikely to help him or her, this reduces the chance of getting help from professionals. Additionally, the decision to seek help will depend on how the symptoms are interpreted by the individual. Underlying beliefs, assumptions, and thoughts are the basis of such an interpretation.³⁸ For example, previous research conducted in Sri Lanka showed that religious beliefs could sometimes give meaningful interpretations to stressful events. In one particular study, 80% of traumatized individuals used religion to give meaning to negative experiences that they are going through.³⁹

A recent survey conducted in 2021 by BWJ with workers, supervisors, and managers, looks at workers' concerns in the garment sector and the grievance mechanisms available to them. There are several grievance mechanisms available to workers, including internal resources such as supervisors, human resource officers, and the union labor committees inside the factory, and external resources such as the union, ministry of labor, and legal resources. The survey results show that overall, 80% of workers indicated being satisfied with grievance mechanisms, with some differences observed: workers reported being more comfortable approaching supervisors with problems, followed by the HR manager, bipartite committee members, and trade union representatives. Looking specifically at the bipartite committees, whose role includes resolving conflicts between managers and workers, workers indicated that such committees would be effective if workers knew about them. The survey found that there is a lack of knowledge among workers about the committee, particularly among Jordanians. 28% of Jordanians and 16% of migrant workers were unaware of the committee.⁴⁰

The survey also explored the level of trust between workers, supervisors, and managers. 96% of managers, 76% of supervisors, and 69% of workers indicated that they believe there is mutual trust in the workplace. Differences across nationalities were observed: Indian workers and supervisors were the least likely to think there is mutual trust, whereas Bangladeshi workers and supervisors gave the most positive responses regarding trust.⁴¹



As part of this assessment, workers were asked if they would resort to management, supervisors, or the doctor if they were faced with mental health issues such as feeling sad, anxious, stressed, or lonely. In line with the findings of the survey conducted by BWJ, most male and female workers stated that they would seek help from factory management and staff (including supervisors and doctors). Some indicated that factory management and staff are able to provide solutions. Some indicated that seeking help would depend on the problem, whether it's work-related or personal, and stated confiding in friends if it was something personal or family-related but would go to their supervisors or welfare officers if it was a work-related problem. Very few workers stated that they would not resort to factory management and staff at all. There was no mention of the bipartite committees.

The stigma surrounding mental health and the differences in the levels of knowledge and perceptions around mental health issues, causes and treatment create barriers to addressing mental health issues in the workplace. Negative connotations (as explored in the 'perceptions' section) around mental health issues and individuals create barriers to speaking up and seeking help from management and staff. Cultural differences in perceptions and beliefs create challenges in the way factory management can raise awareness around mental health issues and advocate correct professional treatment.

Failure to correctly address mental health issues in a timely, professional, and appropriate manner can negatively impact workers with mental health issues. This could adversely impact the health and wellbeing of workers and also affect the general morale among other workers. **Incorrectly handling mental health cases can perpetuate existing myths surrounding mental health among workers and staff.**



4.4 Experiences related to mental health issues

Workers, as well as factory management/staff, were asked about the experiences they encountered with individuals going through mental health problems in Jordan and how these problems were addressed. There was a general reluctance to disclose stories of mental health issues and cases of suicides in factories. Furthermore, migrant workers were asked about experiences they encountered with individuals going through mental health problems in their communities and how community members responded in these cases.

The following subsections provide detailed findings.

4.4.1 Experiences encountered in Jordan

Only a few workers shared stories of other workers experiencing mental health problems, as many were reluctant to speak up. Despite efforts by the research team to remind participants that their interviews were anonymous and that no repercussions would result from speaking about what they witnessed in the factories, many were hesitant. Workers from India and Nepal said that they hadn't encountered any workers experiencing mental health problems. Only a few workers from Bangladesh and Sri Lanka and one worker from Jordan recalled some stories. Male workers from Sri Lanka stated that while Sri Lankan workers do not go through such problems, workers from Bangladesh are more likely to, as they have many issues related to "ghost attacks" in their culture. Among reflections shared by workers:

'Yes, we have seen many incidents of ghosts and spiritual issues. For example, there are people who are working, and suddenly they get stuck and shivering and getting fixed and looking at one place. They try to hit people around them and behave so weirdly. So, this is very common. Usually, the person is taken to a separate space, and they try their best to put the person under control. There are spiritual specialists who can support these people. They are supported by those who know about anything related to ghosts, the devil, and spiritual things. If this is also not working, they will refer them to a doctor. That is the very usual procedure.' (Female worker, Sri Lanka)

'I witnessed two cases. Whether it was a mental issue caused by personal problems, I believe it was a personal issue. One of them is a Sri Lankan girl, and the other is a Bangladeshi girl. The Sri Lankan committed suicide 5 to 6 years ago. The Bangladeshi girl killed herself five years later.' (Male worker, Bangladesh)

Furthermore, workers who shared stories spoke about the ways in which the management helps those who have been “attacked by spirits or ghosts.” In most cases, workers are taken to the medical/sick room, and a “holy person” such as the Mullah or Sheikh is brought in to recite the Quran, or other religious texts to calm the worker down.

‘We have never seen anything as such among the Sri Lankan workers. But mainly, we have seen a lot of cases among Bangladeshi workers. This is pretty common. They would normally be walking and suddenly claim they have a ghost or a spiritual issue. They would either take them to the medical room or the nurse. There are also particular people known as Mullah; you know the people who preach and who have long beards. They would take them to the Mullah who would pray for them, and then they would become okay.’

(Male worker, Sri Lanka)

‘Yes, one time, a Sri Lankan girl started screaming, and she put her hair under the sewing machine. In cases like this, they first try to hold them down, away from the sewing kit and anything sharp. Then they take them to the doctor’s clinic until they calm down. Sometimes they bring a sheikh to recite the Quran for them. There was a time when this was happening a lot. So, they stopped playing music and started putting the Quran on the speakers to calm everyone down.’

(Female worker, Jordan)

Some female Jordanian workers from different factories, spoke about the bad treatment they have experienced by supervisors, including shouting and screaming. One worker elaborated that when she started working at the factory, she was still a beginner and learning. However, she had a supervisor who constantly shouted and screamed at her as a way to increase her productivity and target. She explained that such treatment impacted her well-being and made her feel helpless.

“There wasn’t anything I could do about it. There was a target, and I had to meet it, but I was still a beginner and couldn’t meet the target. They wanted instant full productivity from me... I just worked harder to avoid hearing such talk from the supervisor. I used to cry myself to sleep and wake up crying.”

(Female worker, Jordan)

While some stakeholders from factory management and staff openly discussed cases of mental health problems at the factory, others stated that such cases rarely or never happen. Some factory management and staff members stated that they have never experienced any mental health problems among workers that are worth recalling. Others were more open and mentioned cases of depression and suicide. Among reflections shared stakeholders:

‘We had one [Jordanian female] worker who was depressed. If she could sleep at the factory, she would. But why, we wondered where her husband and children were? She then told us that her husband keeps hitting her. Any chance of staying at the factory, working overtime, working on Fridays, she would take it. She was very sad, self-isolated, always working.’

(Female HR officer, Jordan)

‘There was a recent case, because the brother just passed away just suddenly because of COVID so this worker went to the dormitory while everybody was working. All of a sudden, I received a call from the dormitory supervisor saying that someone was crying very loudly. So, I sent the translator, but the girl didn’t want to talk, and then the translator just sat beside her for a few hours while she was crying until she calmed down. After that, she opened up to us about what happened, and we asked her how we could support her. After a few days with the translator and some friends coming in, she went back to work, and she’s performing well in the production line.’

(Female HR manager, Malaysia)



Cases of suicide that were mentioned by factory management and staff were all perceived to be a result of family or relationship problems rather than reasons related to the work environment, pressure, or living conditions. Among reflections shared stakeholders:

‘We had two suicides; one was a female Bangladeshi worker, she was good at work, she did not complain or submit complaints, she hung herself in her room. After that, we checked with her roommates; the only thing they knew was that she was having a fight with her mother over financial issues, but otherwise, workwise or in the room, she did not exhibit any symptoms. The other guy had a serious drinking problem; he assaulted one of the girls, so we terminated his contract. So, he was officially not our employee; he was just waiting to leave, he left a note in a way he wanted to get some kind of revenge on the girl, so by committing suicide, he would put the blame on her. For her, we had a matron sleeping in her room for almost 2-3 weeks until we made sure she was okay.’

(Male factory management representative, India)

‘A few days ago, there was a suicide case. The girl loved a guy, and her family disapproved, so that’s why she committed suicide and the guy [in another country] also committed suicide. Not a single case of suicide is because of factory conditions; it’s mostly because of personal issues. The nationality is usually Bangladesh.’

(Female dorms supervisor, Bangladesh)



4.4.2 Experiences encountered in the home country

Most migrant workers claimed to have encountered someone experiencing mental health issues back home. Workers from Bangladesh were more likely to provide personal examples of how they or family members had directly suffered mental health problems. More than half of the participants said they had come across someone with mental health problems in their home country. Numerous workers said they had experienced these people in the streets, in school, or the broader community. In contrast, workers from Bangladesh tended to share more personal stories about how they or members of their family were afflicted by mental health problems.

'I am an example of this because I don't have a mother or a father. They all died, and there's nobody to take care of me, so I suffer from mental health pressure.'

(Female worker, Bangladesh)

'I encountered this in my family back home.'

(Female worker, Bangladesh)

'A person in school, he had a similar mental health problem. He would act very normally, and suddenly within seconds, he would act very weird, showing different physical reactions and physical behaviors. He would start shaking, not drinking water, shouting at people, etc.' *(Male worker, Sri Lanka)*



Across all nationalities, there was no clear answer as to how these societies treated or accepted mental health problems. Participants shared a variety of explanations saying that while some individuals might be accepting or supportive, others might treat victims apathetically, and oftentimes violently. Workers tended to share a variety of answers to this question, indicating that treatment of mental health victims exists on a spectrum (Supportive-->Indifferent/Ignore-->Violent). One female worker from Nepal poignantly described how treatment depends on education levels as well as geographical location. She explained that people with higher levels of education and who are living in the city tend to be more accepting than those with less education and living in villages. This explanation suggests that an increase in targeted mental health awareness programs and advocacy campaigns in less urban areas might contribute to making these societies more tolerant.

“

‘In my society, people who live in the city and are educated support people with mental health. But in the village the situation is different, they don’t treat them well, and they do not talk to them and do not support them and they afraid from them’

(Female worker, Nepal)



Numerous workers claimed that individuals would be supportive by lending financial assistance, food, or seeking to talk to these people. However, several other participants claimed that members of their communities would be scared of that person and attempt to ignore and or isolate them. Workers from both Sri Lanka and Bangladesh shared that people suffering from mental health problems might be “tied” down or “chained” in an effort to contain the threat that they pose. The inconsistency of answers across all nationalities suggests that societal treatment and acceptance of mental health victims in these countries are inconsistent. In the worst cases, it might lead to inhumane treatment of the victim.

Table 7 - Treatment of individuals suffering from mental health problems in the home country

POSITIVE EXAMPLES	<p>‘They will provide mental refreshers, supporting him, consolidating him, talking to him softly, and they try all the best things for him and help him.’ (Male worker, India)</p> <p>We should explain to them and make it more acceptable because if we all take care of each other in society, everyone will be happy.’ (Male worker, Nepal)</p>
INDIFFERENT EXAMPLES	<p>‘They kind of expressed the social reaction and said it depends on the individuals in the society - some people will completely shut those people out, not talk to them and have a boundary.’ (Female worker, Sri Lanka)</p>
AGGRESSIVE EXAMPLES	<p>‘Some would isolate them and lock them by a chain.’ (Female worker, Bangladesh)</p> <p>‘So, the community held the person and first tied his legs, try to calm down the person and then try to give them a bit of water, etc... And then there are the religious chanting and then tied hands.’ (Female worker, Sri Lanka)</p>



Only one worker from Sri Lanka suggested that this person should be treated by a psychiatrist or doctor who specializes in mental health problems. Several workers from other countries explained that someone with mental health problems should be admitted to a hospital for treatment. However, the fact that only one participant was able to identify specialized psychiatric help as a solution, highlights low levels of awareness about how best to help those suffering from mental health issues.

Workers from India were more likely to give preference to religious or spiritual cures to mental health problems. Multiple responses by workers from India indicated that the first course of action for solving someone's mental health disorder would be seeking out religious counsel from an Imam or a spiritual healer. They explained that in the case that the victims were not religious, or that the religious assistance did not solve the problem, the hospital or a doctor would be the next best solution. These responses highlight a greater reliance on religious and spiritual solutions amongst Indian workers.

'First, people will take the person to an Imam or spiritual healer, and if they're not okay, they will take him to the hospital.'

(Male Worker, India)

'If there is a person back in his village who had a certain behavior, they would take him to the Imam who has a spiritual function. They would keep him there until he says the person is okay. If the problem is not spiritual, they would take him to the hospital.'

(Male Worker, India)

4.4.3 Discussion: experiences

There was a reluctance by workers, especially migrant workers, to talk about stories or instances of other workers experiencing mental health problems. Even though workers were reminded that the information they provide will remain confidential, very few recounted stories of mental distress or incidents of suicide taking place in the factory. This reluctance could possibly be due to i) workers not being open or used to discussing mental health issues freely and comfortably, and/or ii) fear of retribution if the information is shared about the factory.

As a result, very few workers shared stories of other workers experiencing mental health problems. Some female Jordanian workers from different factories, spoke about verbal abuse they have experienced by supervisors, including shouting and screaming.

Results from the 2021 survey conducted by BWJ with workers, supervisors, and managers in the garment sector found that verbal abuse is the most common concern cited by workers, as 36% of workers stated this concern – the highest percentage since 2019. In line with findings from this assessment, the survey found that concerns related to verbal abuse were mostly driven by Jordanian workers, as 62% reported being concerned with verbal abuse. Additionally, concerns with sexual harassment increased among workers from Jordan, Bangladesh, and Nepal and were most likely to be reported by Jordanians.⁴²

4.5 Further insights

4.5.1 Collective Bargaining Agreement (CBA)

Most stakeholders – factory management and staff – did not mention any concrete changes in their factories following the addition of the worker wellbeing clauses to the CBA. The CBA was created in 2013 and included a unified contract for all migrant workers and further regulated other aspects, including work hours, wages and bonuses, and health and occupational safety. In 2019, additional clauses were added relating to workers' well-being.

'As a sector, I don't see a major change. What you are doing and the trainings that Better Work is arranging are all efforts to address this. Just because it's in the collective bargaining agreement, it doesn't mean it's addressed.'

(Male factory management representative, India)

Some stakeholders (factory management and staff) claimed that their factories had already tackled worker well-being issues even before these clauses were added. Some gave examples, including conducting open days, food fairs, and other extra-curricular activities in a way to enhance workers' well-being. Other examples included celebrating national days of migrant workers and going on field trips.

Generally, the knowledge of most stakeholders regarding the CBA additional clauses was low, as some did not know what the question was referring to. Given this low level of knowledge, it is expected that the workers' knowledge of the agreement and its clauses is also low. One management representative stated that the changes had been read out to workers through the public announcement system. However, he doubts that the information was absorbed by the workers.



4.5.2 Embassy procedures

The two embassy representatives stated that their embassies receive complaints periodically through a hotline number, WhatsApp messages, or specific online systems. For example, one stated that the embassy received around 10-15 complaints per month. The number of complaints increased with the start of the COVID-19 pandemic but returned to its normal rate in 2021. One representative expressed that the rate of complaints from factory workers decreased significantly after the introduction and enforcement of stringent work and living regulations in the past few years.

‘In the government of India, we have 3-4 systems for that; one is an online system called Madad, Madad in Hindi means help, so anybody can raise their complaint, help, or require, so that can be done online. Then they send most often these complaints through WhatsApp voice messages.’ (Representative, Embassy of India)

While complaints are not explicitly regarding mental health, many relate to factors that cause stress and anxiety for workers. Most complaints received relate to pay issues, overtime, and other work matters. During the COVID-19 pandemic, there were many complaints and requests by workers to travel back home.

‘They do not call saying mental health, but actually what they are saying is that when their family members are ill, they say they want me to go back, and they are very stressed. Then they will ask, “why should we work? Our relative died, what is the purpose of working?” by their question, we understand they are stressed, but even though they are not using the term’. (Representative, Embassy of India)



In the cases of suicide, the embassy is informed and takes certain procedures. The embassy investigates the cause of death and communicates with the worker's family back home to deliver the news.

'In any case of death, we first try to learn the causes; we try to know if they were sick, what measures were taken if they got the proper treatment. The problem when it's a suicide case, or in all cases, we talk to the families in Bangladesh their roommates to understand what the reason was and why. Most cases we find in the garment sector are emotional cases. Some cases, with the husband, maybe he married again back home, so she became mentally stressed.'

(Embassy of Bangladesh)

4.5.3 National Mental Health & Substance Use Action Plan (2022-2026)

The Ministry of Health representative interviewed spoke about the **National Mental Health & Substance Use Action Plan (2022-2026)** and how it addresses different issues of mental health in Jordan. It was explained that the Ministry of Health is working on the action plan with the WHO and Mental Health and Psychosocial Support (MHPSS) actors, who all come from unique backgrounds and expertise. The main highlight in the action plan draft is that the National Technical Committee (NTC) will review the [National Policy for Mental Health \(2011\)](#) to assess gaps and areas in need of an update. Additionally, part of the Action plan focuses on the issue of suicide and depression. Another focus of the strategy is the mental health gap (MHGAP), or how mental health is incorporated in primary health care. In other words, the aim is to reach a point where when a patient goes to a health care center, any mental health issues or needs can be identified by the health care provider. However, it is unclear if migrant workers as a group are specifically included in the strategy.



5. Summary of findings

Theme	Findings	Implications
Knowledge of mental health problems	<p>This research found that workers and stakeholders demonstrated varied levels of knowledge around mental health problems and causes. Workers exhibited lower levels of knowledge than stakeholders. The group of workers that demonstrated the most knowledge on the issue was Jordanian workers, and especially female workers. While stakeholders have higher levels of knowledge around mental health issues, there are still some groups, especially factory staff, who exhibited limited knowledge on the subject.</p> <p>While the majority correctly identified that extreme psychological stress from major life events can cause mental health problems, there were mixed opinions as to whether biological or spiritual factors can potentially cause mental health problems. Some migrant workers, particularly those from India and Bangladesh, believed that spiritual factors (such as being cursed or possessed) cause mental health problems.</p>	<p>Lack of knowledge around mental health problems and causes is problematic because it impacts the way management and staff interpret and diagnose mental health problems and, in turn, provide the proper course of treatment as well as the willingness and responsiveness of workers to seek or accept the correct treatment.</p>
Knowledge of mental health causes	<p>While the majority correctly identified that extreme psychological stress from major life events can cause mental health problems, there were mixed opinions as to whether biological or spiritual factors can potentially cause mental health problems. Some migrant workers, particularly those from India and Bangladesh, believed that spiritual factors (such as being cursed or possessed) cause mental health problems.</p>	
Knowledge of mental health treatment	<p>Overall, there is limited knowledge of mental health treatment. Much of this is due to a lack of a proper diagnosis, as participants focused on physical ailments and did not manage to identify the mental health problems (especially the more advanced cases). There were a few recommendations to see a psychologist, but the majority of workers (especially migrants) suggested spiritual treatment.</p>	

Theme	Findings	Implications
Perceptions of mental health and individuals exhibiting mental health conditions	<p>This assessment found that there are negative connotations associated with mental health and those suffering from mental health issues. This was evident by some of the words used by workers and stakeholders to describe individuals going through mental health problems, including “anger”, “difficulty in dealing”, “crazy”, “insane”, and “disturbed”. This was confirmed by stories cited by workers about individuals going through mental health problems and how they were treated in their communities. Participants shared a variety of explanations regarding the way their communities treated individuals suffering from mental health issues, saying that while some individuals might be accepting or supportive, others might treat victims apathetically, and oftentimes violently – by attempting to ignore and or isolate them. Workers from both Sri Lanka and Bangladesh shared that people suffering from mental health problems might be “tied” down or “chained” in an effort to contain the threat that they pose.</p> <p>There are differences across nationalities in the way workers perceive mental health issues and causes. Among notable differences was the issue of religion and faith, which was only brought up by Jordanian workers who believed that individuals who have faith in God are less likely to go through severe mental health issues. Another difference is the strong belief in spiritual causes, such as being possessed by ghosts or the devil, which was expressed by some migrant workers.</p>	<p>The stigma surrounding mental health creates many barriers. The differences in perceptions around mental health issues and causes greatly impact the extent to which mental health patients are willing to disclose or talk about their mental health problems, their willingness to seek help, and their inclination to accept medical treatment. Those who are in an environment or community that stigmatizes mental health issues are less likely to be open about their mental health issues. Furthermore, negative connotations with mental health and individuals going through mental health problems will likely impact how management, staff, and workers treat those suffering from mental health issues, increasing the likelihood of exclusion and stigmatization.</p>

Theme	Findings	Implications
Attitudes towards seeking help	<p>Several factors impact the likelihood of workers in seeking help as well as the type of help they seek. Barriers to seeking help from factory management and staff include: i) the fear that problems will become bigger and more exposed, resulting in the spread of rumors; and ii) fear retribution. However, those who stated that they would seek help from factory management and staff stated that factory management and staff tend to have solutions to problems. Many workers stated that they would confide in friends with personal problems as friends can be trusted in keeping problems private.</p> <p>The stigma surrounding mental health and the differences in the levels of knowledge and perceptions around mental health issues, causes and treatment create barriers to addressing mental health issues in the workplace. Negative connotations (as explored in the ‘perceptions’ section) around mental health issues and individuals create barriers to speaking up and seeking help from management and staff. Cultural differences in perceptions and beliefs create challenges in the way factory management can raise awareness around mental health issues and advocate correct professional treatment.</p>	<p>Failure in correctly addressing mental health issues in a timely, professional, and appropriate manner can negatively impact workers with mental health issues. This could adversely impact the health and wellbeing of workers and also affect the general morale among other workers. Incorrectly handling mental health cases can perpetuate existing myths surrounding mental health among workers and staff.</p>
Experiences related to mental health issues	<p>There was a reluctance by workers, especially migrant workers, to talk about stories or instances of other workers experiencing mental health problems. This reluctance could possibly be due to a lack of confidence in openly discussing mental health issues and problems and/or fear of retribution.</p> <p>Some female Jordanian workers from different factories, spoke about verbal abuse they have experienced by supervisors, including shouting and screaming. This finding is in line with results from the 2021 survey conducted by BWJ with workers, supervisors, and managers in the garment sector, which found that verbal abuse is the most common concern cited by workers, as 36% of workers stated this concern – the highest percentage since 2019. Concerns related to verbal abuse were mostly driven by Jordanian workers, as 62% reported being concerned with verbal abuse.⁴³</p>	

Theme	Findings	Implications
	<p>Furthermore, workers who shared stories spoke about the ways in which the management helps those who have been “attacked by spirits or ghosts.” In most cases, workers are taken to the medical/sick room, and a “holy person” such as the <i>Mullah</i> or <i>Sheikh</i> is brought in to recite the Quran, for example, or other religious texts to calm the worker down.</p> <p>While some stakeholders from factory management and staff openly discussed cases of mental health problems at the factory, others stated that such cases rarely or never happen. Cases of suicide that were mentioned by factory management and staff were all perceived to be a result of family or relationship problems rather than reasons related to the work environment, pressure, or living conditions.</p> <p>Most migrant workers claimed to have encountered someone experiencing mental health issues back home. Across all nationalities, there was no clear answer as to how these societies treated or accepted mental health problems. Participants shared a variety of explanations saying that while some individuals might be accepting or supportive, others might treat victims apathetically, and oftentimes violently. Workers from India were more likely to give precedence to religious or spiritual cures for mental health problems. Multiple responses by workers from India indicated that the first course of action for solving someone’s mental health disorder would be seeking out religious counsel from an Imam or a spiritual healer.</p>	

6. Recommendations

National level – Ministries and Trade Union

- Ensure that the National Mental Health & Substance Use Action Plan (2022-2026) addresses issues faced by migrant workers in Jordan relating to mental health and wellbeing, especially focusing on the issue of mental health illness and suicide cases.
- Involve stakeholders from the garment industry in the national task force working on the National Mental Health & Substance Use Action Plan (2022-2026) to ensure that issues related to migrant workers in Jordan are mainstreamed in the action plan.
- Raise the level of knowledge of most stakeholders regarding the additional clauses relating to mental health in the Collective Bargaining Agreement.
- Increase inspections by the MOL to ensure that factories are abiding by labour regulations and providing decent work conditions.
- Create a referral system in which factories, embassies, the trade union, and ministries are a part; to provide the appropriate supportive and protective measures for migrant workers.
- Arrange for the hotline to be available in the different languages of migrant workers to ensure that they can properly communicate grievances. This could be coordinated with the embassies of migrant workers.
- Develop factory-level protocols in collaboration with the Ministry of Health to deal with suicide cases in the garment sector, including prevention, response, and post-response.

National level – embassies of migrant workers

- Create shelters as part of the embassies of migrant workers, or arrange for shelters, to ensure that workers facing abuse or harassment, threatening or intimidation, or legal action with the factory have a safe place to be in until problems are resolved. This is particularly important for female workers who are subjected to sexual harassment at factories.
- Create a referral system in which factories, embassies, the trade union, and ministries are a part; to provide the appropriate supportive and protective measures for migrant workers.
- Conduct investigations behind deportation cases to identify the reasons behind workers getting deported.
- Conduct regular information/awareness/cultural sessions and events with workers. This should be cultural and language-specific and should include some activities that are informative and others that are recreational to raise awareness and enhance the wellbeing of workers and create a sense of community.
- Provide legal support for migrant workers who are facing violations/abuse/mistreatment.

Factory management and staff

- Create a clear referral system, in collaboration with mental health experts, ministries, embassies, and the trade union, and streamline it across factories to ensure the proper handling of mental health cases. This process should be collaborative and should involve all stakeholders to ensure buy-in.
- Clearly communicate MH plans and procedures to workers and ensure they are well informed and know how to communicate grievances and where to get help.
- Assign a yearly budget for mental health support or services.
- Further raise awareness of factory management and staff on mental health disorders, causes, and solutions.
- Enhance ethical consideration around the treatment of mental health patients by ensuring the privacy and confidentiality of patients as the assessment showed that one barrier to seeking help is the fear of rumors spreading about them.
- Increase extra-curricular activities that enhance well-being included rest, exercise, cultural activities, and nutritious food, as most stakeholders stated that these are important factors that contribute to good mental health.
- Enforce strict policies to prohibit verbal and physical abuse as verbal abuse was cited as a concern by some Jordanian female workers.
- One important recommendation is to further build the capacity of factory staff, including welfare and medical officers, as they are the most likely to deal with workers exhibiting mental health issues.
- Work to enhance the recreational facilities inside the factories, like GYM, cinemas, break rooms, and prayers room.

Workers

- Nationality and culture-specific differences have to be taken into consideration when designing workshops around mental health issues, as these nuances will impact how receptive workers are to these workshops and to what extent their perceptions can change.
- It is recommended that workshops are disaggregated by nationality to allow participants from the same nationality to reflect and elaborate on their social, religious, and cultural beliefs. This will also allow the trainers to dig deep into myths and beliefs that are culture-specific.
- It is recommended that professional trainers from these countries (Sri Lanka, Bangladesh, Nepal, etc.) are recruited to help design/implement workshops.
- The findings show that there is a willingness by some workers to seek professional medical help. This should be further encouraged during workshops. One way to reduce the stigma of seeking medical help is to assign a mental health professional and to locate them in the medical clinic, as workers frequently mention their readiness to go to the resident doctor. This way, the provision of mental health services can be linked to physical ones, thus reducing barriers to seeking help.
- Raise the awareness of workers on their rights, CBA clauses, and grievance mechanisms.

Annex 1 - Sample breakdown

Table 1 - Interviews with external key informants

External key informants			
1	Embassy of India	First Secretary	In-person
2	Embassy of Bangladesh	Labour Attaché	In-person
3	Ministry of Health	Director of Mental Health and Disability Directorate	In-person
4	J-Gate	Executive CEO	In-person
5	Trade Union	President of the Trade Union	In-person
6	Ministry of Labor	Health and Occupational Safety Unit	In-person

Table 2 - Interviews with internal key informants

Internal key informants						
1	Factory management	Garment factory 1	Ajloun	Arabic	N/A	In person
2	HR officer	Garment factory 1	Ajloun	Arabic	N/A	In person
3	Medical officer	Garment factory 1	Ajloun	Arabic	N/A	In person
4	Factory management	Garment factory 2	Dulayl	English	N/A	In person
5	HR officer	Garment factory 2	Dulayl	English	N/A	In person
6	Welfare officer	Garment factory 2	Dulayl	Bangla	Sumana	Remotely
7	Medical officer	Garment factory 2	Dulayl	Arabic	N/A	In person
8	Factory management	Garment factory 3	Sahab	Arabic	N/A	In person
9	HR officer	Garment factory 3	Sahab	Arabic	N/A	In person
10	Welfare officer	Garment factory 3	Sahab	English	N/A	In person
11	Medical officer	Garment factory 3	Sahab	Arabic	N/A	In person
12	Dorm supervisor	Garment factory 3	Sahab	Bangla	Sumana	Remotely
13	HR manager	Garment factory 4	Irbid	English	N/A	In person
14	Dorm supervisor	Garment factory 5	Irbid	Bangla	Sumana	Remotely
15	Former union organizer		N/A	N/A		Remotely

Table 3 - FGDs with workers

FGD with workers							
1	Females	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
2	Females	Jordan	Garment factory 2	Dulayl	Arabic	No translation	In person
3	Males	Jordan	Garment factory 3	Sahab	Arabic	No translation	In person
4	Females	Bangladesh	Garment factory 2	Dulayl	Bangla	Translation	Remotely
5	Females	Bangladesh	Garment factory 3	Sahab	Bangla	Translation	Remotely
6	Females	Sri Lanka	Garment factory 2	Dulayl	Sinhalese	Translation	Remotely
7	Males	India	Garment factory 3	Sahab	Hindi	Translation	Remotely
8	Males	India	Multiple		Hindi	Translation	Remotely
9	Females	Nepal	Garment factory 3	Sahab	Hindi	Translation	Remotely
10	Males	Nepal	Garment factory 3	Sahab	Hindi	Translation	Remotely
11	Males	Sri Lanka	Garment factory 5	Irbid	Sinhalese	Translation	Remotely
12	Females	Sri Lanka	Garment factory 5	Irbid	Sinhalese	Translation	Remotely

Table 4 - IDIs with workers

IDIs with workers							
1	Male	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
2	Male	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
3	Female	Jordan	Garment factory 2	Dulayl	Arabic	No translation	In person
4	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
5	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
6	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
7	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
8	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
9	Female	Jordan	Garment factory 1	Ajloun	Arabic	No translation	In person
10	Female	Bangladesh	Garment factory 3	Sahab	Bangla	Translation	Remotely
11	Female	Bangladesh	Garment factory 5	Irbid	Bangla	Translation	Remotely
12	Male	Sri Lanka	Garment factory 5	Irbid	Sinhalese	Translation	Remotely
13	Female	Sri Lanka	Garment factory 2	Dulayl	Sinhalese	Translation	Remotely
14	Female	Sri Lanka	Garment factory 2	Dulayl	Sinhalese	Translation	Remotely
15	Female	Sri Lanka	Garment factory 2	Dulayl	Sinhalese	Translation	Remotely
16	Female	Nepal	Garment factory 3	Sahab	Hindi	Translation	Remotely
17	Male	Nepal	Garment factory 3	Sahab	Hindi	Translation	Remotely
18	Male	Nepal	Garment factory 5	Irbid	Hindi	Translation	Remotely
19	Male	India	Garment factory 5	Irbid	Hindi	Translation	Remotely

Annex 2 – Tools

Focus group discussions and interviews with workers

Introductory text: *Hello, my name is X. I am a researcher from the Information and Research Center – King Hussein Foundation. We have been contracted by Better Work Jordan to conduct an assessment of mental health. I will be asking you some questions about your opinions and knowledge on the topic. I would like to stress that there are no right or wrong answers; you are free to discuss anything that comes to your mind. All information that will be discussed here will be confidential. This means that your name or private information will not be mentioned anywhere. The information that we discuss together will be written out as general findings in the final report. The report will provide recommendations on how to effectively support workers in terms of mental health services.*

I have X and Y with me today. X will be translating, and Y will be taking notes. Before we start, I would like to take permission to record this focus group / interview. No one will listen to the recording except for Y and myself, as we will be analyzing the data later. Is everyone okay with recording?

Round of introductions.

For FGDs, fill in the demographic information:

	P1	P2	P3	P4	P5	P6
Name						
Sex						
Age						
Marital status						
Nationality						
Factory name						
Position in factory						
Duration in Jordan						
Duration with current employer						

Okay, let us start. I will ask you some general questions. Please remember that you can talk freely. Let us try to take turns so that we can hear each other clearly.

1. If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person? (Knowledge, perceptions)
2. If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can't focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person? (Knowledge, perceptions)
3. If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these behaviors? What do you think should be done to help this person? (Knowledge, perceptions)
4. I will now tell you a story. At some points, I will stop and ask you questions about what you think of the story and the characters in it. (Attitudes)

Ahmad and Kareem are roommates. They are construction workers on a site in a remote location. Their work is physically tough, as they must work for more than 8 hours a day under the heat. Ahmad and Kareem are also away from their family and only get to visit their wives/children every two years. Ahmad has been noticing that Kareem's behavior has been changing for months, especially after he found out that his mother has a bad case of COVID-19 back home. At first, Kareem stopped engaging and talking to people around him. Then Ahmad noticed that Kareem talks to himself sometimes and catches him staring at the wall for long periods.

- a. What do you think is happening with Kareem?
- b. What do you think caused this?

Two months later, Kareem's behavior kept changing. Ahmad was worried about his roommate and friend, and so he sat with Kareem and asked him what was happening with him. Kareem said that he hears voices in his head. The voices often tell Kareem that 'there is no point' and that Kareem should 'end his life' to find peace.

- c. What adjectives would you use to describe Kareem?
 - d. Do you think Ahmad should be worried about his safety?
 - e. Do you think Kareem is dangerous?
 - f. What do you think is the best way to help Kareem?
5. Please tell me what comes to mind when you hear the term 'mental health'? (Knowledge, perceptions)

6. Do you think mental health problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members, moving to a new country, etc.?) Why or why not? (Knowledge)
7. Do you think that mental problems or disorders may occur as a result of spiritual factors, such as a person being cursed? Why or why not? (Knowledge)
8. Do you think that mental disorders are caused by biological factors, such as genetics? Why or why not? (Knowledge)
9. Do you think strong and healthy individuals can still have mental health problems? Do you think individuals with mental health problems can/should be working in settings such as factories, construction sites, etc.?
10. Do you think exercise, rest, good living conditions, and having a support network (friends and family) are enough to contribute to better mental health? (Knowledge)
11. Have you ever encountered someone experiencing a mental health problem in your community back home? (Experiences)
 - a. How was this person treated? How did the community react?
 - b. What was done to help the person?
 - c. How does your community perceive mental health issues?
12. Have you ever encountered someone experiencing a mental health problem during your time in Jordan? (Experiences)
 - a. How was this person treated? How did the management/ co-workers react?
 - b. What was done to help the person?
13. If you are faced with a mental health issue [for example, feeling sad, anxious, stressed, lonely, etc.], would you talk to your supervisor, management, or medical staff about it? Why or why not? (Experiences)
14. If you are faced with a mental health issue [for example, feeling sad, anxious, stressed, lonely etc.], do you know where and how to seek help? What would you do? (Experiences)
 - a. What do you think would help you in this case? [Think of resources that are not currently available but should be put in place to help you]
15. What are the social media applications that you and your colleagues use the most?
16. How does social media make you feel? [probe to explore if it provides a positive or negative effect – connecting with friends and family, distressing or dealing with bullying, social pressure, etc.]

Interviews with Stakeholders

Introduction before each interview: *hello my name is X I am a researcher from the Information and Research Center – King Hussein Foundation. We have been contracted by Better Work Jordan (ILO) to conduct an assessment on mental health. I will be asking you some questions about your opinions and knowledge on the topic. I would like to stress that there are no right or wrong answers, you are free to discuss anything that comes to your mind. All information that will be discussed here will be confidential. The information that we discuss together will be written out as general findings in the final report. The report will provide recommendations on how to effectively support workers in terms of mental health services. Before we start, I would like to take permission to record this interview. This is for our own research purposes, so I can listen to the interview and analyze the data after the interview. Are you okay with recording this interview?*

Factory management, medical staff, welfare officers, HR and dorm supervisors

1. Can you please introduce yourself and tell us a little bit about the factory and your role? Can you tell how you were affected the COVID-19 pandemic?
2. Please tell me what comes to mind when you hear the term ‘mental health’?
3. If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
4. If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can’t focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
5. If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
6. Do you think that mental health problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members, moving to a new country etc.?) Why or why not?
7. Do you think that mental health problems or disorders may occur as a result of spiritual factors, such as a person being cursed? Why or why not?
8. Do you think that mental health problems or disorders are caused by biological factors, such as genetics? Why or why not?

9. If a worker is exhibiting signs of mental distress (like sleep problems, irrational thoughts, sadness, social withdrawal.), do you think they should be referred to a doctor? Why or why not?
 - a. If not, where should the worker be referred to?
10. If a worker is exhibiting signs of mental distress, do you think they should be treated differently? [Explore treatment on both ends of the spectrum: softer and more lenient treatment (they should be given more attention, work less, rest more, spoken to delicately) or harsher treatment (more strict, more direct)]?
11. What adjectives would you use to describe a worker exhibiting signs of mental distress?
12. Have you ever had a worker experiencing a mental health problem? Can you please describe the situation? How did the factory handle it? [Additional for all groups other than management: would you have wanted to address the situation differently but weren't able to? Please explain.]
13. [To the medical staff] do workers come to you with psychological symptoms or social problems? What actions do you take in this case? And do you feel confident dealing with such issues?
14. In your opinion, what is the general state of mental health of migrant workers at your factory? Do you think it is something that should be of concern? Why or why not?
15. [To the management and HR] Are there any procedures to assess workers' mental health before coming to Jordan? [is mental health considered when the health check-up is conducted before coming to Jordan?]
16. [To the management and HR] How do workers raise concerns related to mental health/ psychological needs? Who addresses these concerns, and what actions are taken? [probe: to ask if workers are referred and to whom, if they are taken to the embassy etc.]
17. [To the management and HR] What (if any) changes had the factory made since the addition of the worker well-being clause to the 2019 Collective Bargaining Agreement (CBA)? Do any of the changes relate to mental health policies or services?
18. [To the management and HR] How and when are workers informed of the existence and contents of the most recent CBA 2019?
19. [To management and HR] To what extent would you be willing to provide mental health services or to cover the expenses of mental health services for workers? Why or why not?

Union

1. Can you please introduce yourself and tell us a little bit about the union and your role?
2. Please tell me what comes to mind when you hear the term 'mental health'?
3. If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
4. If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can't focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
5. If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
6. Do you think that mental health problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members, moving to a new country etc.?) Why or why not?
7. Do you think that mental health problems or disorders may occur as a result of spiritual factors, such as a person being cursed? Why or why not?
8. Do you think that mental health problems or disorders are caused by biological factors, such as genetics? Why or why not?
9. Do you think exercise, rest, good living conditions, and having a support network (friends and family) are enough to contribute to better mental health?
10. If a worker is exhibiting signs of mental distress, do you think they should be referred to the doctor? Why or why not?
 - a. If not, where should the worker be referred to?
11. If a worker is exhibiting signs of mental distress, do you think they should be treated differently? [Explore treatment on both ends of the spectrum: softer and more lenient treatment (they should be given more attention, work less, rest more, spoken to delicately) or harsher treatment (stricter, more direct)]?

12. What adjectives would you use to describe a worker exhibiting signs of mental distress?
13. In your opinion, what is the general state of mental health of workers? Does it differ between Jordanian and migrant workers? Do you think it is something that should be of concern? Why or why not?
14. How do workers raise concerns relating to working conditions or mental health/psychological needs? Who addresses these concerns, and what actions are taken? [probe: to see if the union plays any role in this area etc.]
15. What (if any) changes have factories made since the addition of the worker well-being clause to the 2019 Collective Bargaining Agreement (CBA)? Do any of the changes relate to mental health policies or services?
16. How and when are workers informed of the existence and contents of the most recent CBA 2019?
17. What do you think of adding mental health services to your health services in Dulail clinics?

Ministry of Labor, Ministry of Health, J-Gate

To all:

1. Can you please introduce yourself and tell us about your role at the ministry/ J-Gate?
2. Please tell me what comes to mind when you hear the term 'mental health'?
3. If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
4. If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can't focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
5. If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
6. Do you think that mental health problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members, moving to a new country etc.?) Why or why not?
7. Do you think that mental health problems or disorders may occur as a result of spiritual factors, such as a person being cursed? Why or why not?
8. Do you think that mental health problems or disorders are caused by biological factors, such as genetics? Why or why not?
9. Do you think exercise, rest, good living conditions, and having a support network (friends and family) are enough to contribute to better mental health?

Additional questions to MoL and J-Gate:

10. [MoL and J-gate] Can you please tell us a little about the role that the ministry/J-GATE plays in supporting migrant workers in Jordan [ask specifically about garment workers]?

11. [MoL and J-gate] What policies or structures do you think should be put in place to better support migrant workers' mental health?
12. [J-Gate] What (if any) changes have factories made since the addition of the worker well-being clause to the 2019 Collective Bargaining Agreement (CBA)? Do any of the changes relate to mental health policies or services?
13. [MoL] How many complaints regarding non-compliance violations do you receive per month? How often do you get complaints concerning mental health issues?
14. [MoL and J-gate] In your opinion, what is the general state of mental health of migrant workers? Do you think it is something that should be of concern? Why or why not?

Additional questions for the Ministry of Health

15. To what extent does the National Mental Health Policy in Jordan cover different target groups, including migrant workers?
16. Does the ministry provide mental health services in health centers? Are any provided to migrant workers? If yes, at what cost?
17. How is the mental health of garment workers addressed in the Mental health action plan 2022-2026?
18. Do you happen to have a record of the situation of migrant workers' mental health?
19. As you are leading the mental health services in Jordan via the MHPSS working group, what things could be done to encourage the different stakeholders (NGOs, and INGOs, development organizations) to widen their scope to include the migrant workers?
20. In your opinion, what is the general state of mental health of migrant workers? Do you think it is something that should be of concern? Why or why not?

Embassies and labor attachés

1. Can you please introduce yourself and tell us about your role at the embassy?
2. Please tell me what comes to mind when you hear the term ‘mental health’?
3. If someone is feeling extremely sad, they do not talk to others around them, they do not have an appetite and can barely eat, and they struggle to wake up and find the motivation to get through the day. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
4. If someone is feeling anxious, they often feel like their heart is racing, they sweat, they find it difficult to breathe, they worry about everything, and can’t focus. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
5. If someone is feeling scared from everything and everyone around them, screams and shouts, and exhibits strange physical actions [give examples]. What do you think is happening with this person? Why? What do you think caused these feelings? What do you think should be done to help this person?
6. Do you think that mental health problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members, moving to a new country etc.?) Why or why not?
7. Do you think that mental health problems or disorders may occur because of spiritual factors, such as a person being cursed? Why or why not?
8. Do you think that mental health problems or disorders are caused by biological factors, such as genetics? Why or why not?
9. Do you think exercise, rest, good living conditions, and having a support network (friends and family) are enough to contribute to better mental health?
10. Can you please tell us a little about the role that the embassy plays in supporting migrant workers in Jordan [ask specifically about garment workers]?
11. How many complaints do you receive from workers per month? Did you keep track of the total number of complaints received in 2019 and 2020? Have the numbers been rising or falling over the last 3-5 years? How often do you get complaints concerning mental health issues?
12. What mental health services exist back in (country)? How do those compare to mental health services offered in Jordan?
13. What main cultural attitudes exist in (country) regarding mental health?

14. In your opinion, what is the general state of mental health of migrant workers? Do you think it is something that should be of concern? Why or why not?
15. What policies or structures in the embassy do you think should be put in place to better support migrant workers?
16. What do you do If you want to share information with the (migrant nationally) community in Jordan? What do you think is the best way to approach workers in terms of awareness-raising?

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